LeadingAge Indiana Member Information Form

(used to collect information for 2025 membership dues)

MEMBER INFORMATION

Provider or Organization Name_____

Address_____

City/State/Zip_____

Telephone_____ Medicare ID _____ EIN _____

Key Member Contact (key contact for the facility)_____

Key Member Contact Title_____ Key Member Email_____

Names, titles and emails of other key personnel:

Function	Name	Title	Email
Administration			
Billing Contact/AP			
Nursing			
Marketing			
Human Resources			

Number of employees: Full Time _____ Part Time _____ Total _____

Number of residents served: _____

Planning stages or under construction? ☐ Expected opening date_____

MANAGEMENT

☐ Self-managed

☐ Management company name_____ ☐ For-profit ☐ Non-for-profit

Tax Exempt Status: ☐ 501 (c)(3) ☐ 501 (c)(4) ☐ Other *(please specify)* _____

SPONSORSHIP

Full Name of Parent Company or Sponsor: _____

(Parent organizations are those that have more than one community as part of their overall operation)

Type of Sponsorship:

☐ Community
☐ Fraternal
☐ Government
☐ Hospital
☐ Private Foundation
☐ Religious (include denomination) _____
☐ Union
☐ Other *(please specify)* _____

Service Types – check all that apply at this community

☐ Assisted Living — No. of Licensed Units _____ No. of Unlicensed Units _____ Medicaid Waiver? _____

☐ CCRC/Life Plan Community — No. of Skilled Nsg. Beds _____ No. of AL Beds _____ No. Independent Living Units _____

☐ Skilled Nursing — No. of Beds Total _____ ☐ Medicare certified No._____ ☐ Medicaid certified No. _____

☐ Hospice — Average No. of Yearly Admissions _____

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HOUSING - Enter most recent rental income here _____ year _____ ***(Housing Members Only)***

☐ Market Rate Housing No. of Units _____ ☐ Public Housing Authority No. of Units _____

☐ Tax Credit-Funded Housing No. of Units _____ ☐ HUD Subsidized Housing No. of Units _____

HUD Program Type: Section: ☐221d3 ☐202(old) ☐202 ☐231 ☐232 ☐236 ☐PRAC

☐Other Housing Type (Please specify): _____ No. of Units _____

Home and Community Based Services (HCBS)

If HCBS, specify type(s) of services (check all that apply):

☐ Adult Day Service ❑ Home Health Agency

☐ Adult Day Healthcare ❑ Other_____

☐ Home Health Care

Special Program Types

☐ Adult Day (standalone – no other services) No. Served_____

☐ Hospice Program (standalone – no other services) No. Served_____

☐ PACE Program (standalone – no other services) No. Served_____

☐ Convent No. Served_____

☐ Village No. Served_____

MEMBERSHIP DUES CALCULATIONS

Dues are calculated on a 10-level dues band structure. Each level represents the annual program service revenue collected by an organization at the site level. There are also some special categories that are charged outside the dues band. Please see below.

Program service revenue is defined as the revenue an organization receives from aging services activities are "primarily those that form the basis for an organization's exemption from tax," according to the IRS and how your membership dues are calculated.

It excludes unrelated items such as interest, realized and unrealized gains or losses, special events/activities, charitable contributions and any other services unrelated to the LeadingAge mission.

The program service revenue should come from IRS Form 990, Part I, line 9 of the most recent completed fiscal year.

1. Please report your program service revenue and the fiscal year it represents:

_____ _____

Program Service Revenue **Fiscal Year**

_____

List above the amount of any supplemental IGT/UPL Payments included in the figure above

2. If your organization *does not* file a Form 990 with the IRS, note below, which of the following documents using the IRS definition (above):

☐ The organization's most recent Audited Financial Statement

☐ Medicaid Cost Report

☐ Profit and Loss statement

☐ Rental Income (Housing members only)

If you selected any of the above, please list the amount in the "Program Service Revenue" box above.