LeadingAge Ohio / LeadingAge Member Application

MEMBER INFORMATION

Provider Name _____

Address _____

City/State/Zip _____

Telephone _____ County _____

Website _____

☐ **Investor owned/For-profit** ☐ **Not-for-profit**

☐ Faith-based ☐ Community ☐ Private ☐ Fraternal ☐ Hospital ☐ Government

Number of residents served at this community:_____

Provider site under construction? ☐ Yes ☐ No If yes, expected opening date:_____

KEY MEMBER CONTACTS

Name:

Title:

Email:

Name:

Title:

Email:

Name:

Title:

Email:

Name:

Title:

Email:

SERVICE TYPES (check all that apply at this community)

☐ Independent Living
☐ Assisted Living CCRC/Life Plan Community
☐ Skilled Nursing
☐ Affordable Housing (see section below)
☐ Hospice
☐ Adult Day Service
☐ Home Health Care
☐ Home Care Agency
☐ Community Based Services
☐ PACE Program
☐ Public Housing Authority Village
☐ Palliative Care

REASONS FOR JOINING (check all that apply)

☐ Support for Non-profit Sector
☐ Advocacy and Public Relations Support
☐ Policy and Regulatory Guidance
☐ Education Opportunities
☐ Information/trends
☐ Networking/Community Building
☐ Technology Assistance
☐ Group Purchasing Savings
☐ Referred by another member
☐ Other_____

Member Type and Services Provided Across the Parent Organization

CCRC/Skilled Nursing Facility/Assisted Living/Residential Care Facility/ Independent Living/housing (market rate)– Check all that apply.

☐ CCRC No. of Skilled Nursing Beds _____ No. of Assisted Living Beds _____
No. of Independent Living Units _____
☐ Skilled Nursing Facility No. of Licensed Beds _____ ☐ Medicare certified
☐ Medicaid certified
☐ Assisted Living/Residential Care Facility No. of Units_____ ☐ AL-Waiver
☐ Independent Living/housing (market rate) No. of Units_____

Home and Community Based Services (HCBS) Only-- Check all that apply.

☐ Adult Day Service
☐ Adult Day Healthcare
☐ Home Health Care
☐ Home Health Agency
☐ Hospice Care
☐ Senior Center
☐ Village
☐ Palliative Care
☐ Other_____

Scope of Services

For each of the following services offered to residents, clients or tenants, please indicate whether it is provided by your staff, provided under contract with another company or organization, or you do not provide the service.

Services offered to residents, clients, or tenants	Provided by Staff	Contracted	Do Not Provide
Adult Day Care	☐	☐	☐
Dementia Care/Memory Support	☐	☐	☐
Therapy/Rehabilitation	☐	☐	☐
Geriatric Clinic	☐	☐	☐
Transportation Program	☐	☐	☐
Home Care Services	☐	☐	☐
Home Health Services	☐	☐	☐
Hospice Program	☐	☐	☐
Service Coordination	☐	☐	☐
Developmental and Intellectual Disabilities Services	☐	☐	☐
Meals on Wheels	☐	☐	☐
PACE Program	☐	☐	☐
AIDS Care	☐	☐	☐
Palliative Care	☐	☐	☐
Other (please specify)			

MANAGEMENT

Parent Company Name, if applicable _____

Management Company Name, if applicable _____

HOUSING PROVIDERS ONLY (check all that apply)

☐ HUD	No. of Units_____
☐ Low Income Housing Tax Credits	No. of Units_____
☐ USDA Rural Housing Service	No. of Units_____
☐ Public Housing Authority	No. of Units_____
☐ Other Housing Type	No. of Units _____

If you receive HUD Assistance (check all that apply):

Section: ☐ 202 PRAC ☐ 202 Section 8 Project-based Rental Assistance ☐ Section 8 Project-based Rental Assistance (no Section 202) ☐ 221d3 ☐ 231 ☐ 232 ☐ 236

☐ Public Housing ☐ Housing Choice Vouchers (including project-based vouchers) ☐ HOME ☐ CBDG ☐ Housing Trust Fund

Service Coordinators, (please check all that apply)

☐ Budget-based Service Coordinator(s)
☐ Grant-funded Service Coordinator(s)
☐ No HUD-funded Service Coordinator(s)
☐ Privately-funded Service Coordinators(s)

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MEMBERSHIP DUES CALCULATIONS

Not For Profit Providers - Program service revenue reported on IRS 990, Part I, Line 9 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. It EXCLUDES unrelated items such as interest, realized and unrealized gains or losses, special events/activities, charitable contributions and any other services.

☐ **990 Program Service Revenue** _____ Current Fiscal Year _____

☐ **The organization's most recent Audited Financial Statement**

Audited Amount _____ Fiscal Year _____

☐ **Rental Income (Housing members only)**

Rental Amount _____ Fiscal Year _____

Investor Owned Providers - please provide the revenue from one of the options below.

☐ Tax Form 1120

Revenue Amount _____ Fiscal Year _____

☐ Tax Form 1120S

Revenue Amount _____ Fiscal Year _____

☐ Tax Form 1065

Revenue Amount _____ Fiscal Year _____

☐ **Other – Please specify form or source of information.**

Amount_____ Fiscal Year _____