LeadingAge™ Indiana
inspire. serve. advocate.

SUBSCRIBER MEMBERSHIP APPLICATION

I. General Information *Please print or type all information*

Name of Facility _____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____ Fax ( )_____

E-Mail _____ Website_____

Administrator/Exec. Dir. _____ Title _____

Corporate Sponsor _____

Address _____

Corporate Person _____ Phone( )_____ FAX( )_____

Is your facility JCAHO accredited? Yes ( ) No ( )
If **no**, have you applied for JCAHO accreditation? Yes ( ) No ( )

II. Licensed Capacity

Total Licensed Capacity: _____ (All 5 categories should equal this #)

_____ Nursing Facility (NF-Title XIX Medicaid)

_____ Non-Certified Comprehensive Care

_____ Skilled Nursing (SNF- Title XVII Medicare)

_____ Licensed Residential

_____ Dually Certified (SNF/NF)

Please list the number of beds for the following types of units:

_____ Sub-acute

_____ Alzheimer's

_____ Other (Describe) _____

III. Unlicensed Capacity

Please list the number of ***unlicensed units*** in the following categories:

_____ Assisted Living

_____ Unlicensed Residential Care

_____ Independent Apartments/Congregate living

_____ HUD Subsidized Apartments

_____ Cottages

_____ Duplexes (list total number of units available)

_____ Other (please describe)_____

IV. Community Based Services

Please indicate if you provide these additional community based services.

_____ Adult Day Care How many clients do you serve? _____

_____ Home Health Care _____Child Day Care

_____ Respite Care _____ Meals on Wheels

_____ Hospice _____ Transportation

_____ Congregate Meal Site _____ Outpatient Therapies

_____ Homemaker Services (Chore Services-shopping, cleaning, laundry etc. to the outside community)

_____ Other Services (please describe) _____

_____

Do you have an In-house Pharmacy to service your residents? _____

V. About Your Staff (Please supply names/email addresses of the following departments)

Health Center Administrator_____

Housing Manager_____

Director of Nursing_____

Activities Director_____

Social Service Director_____

Food Service_____

Housekeeping_____

Maintenance_____

Human Resources_____

Business Office_____

Marketing/Admissions_____

Resident Services_____

VI. For Government Relations

The following information is for internal use only and your facility will not be identified. It may be used in an aggregate form to assist LeadingAge Indiana in lobbying efforts to better serve you.

Number of Full Time Equivalents (FTE)_____ Annual Payroll_____

Gross operating revenue_____ Expenses_____

Average # of total residents on your campus _____

Average occupancy (number of residents) in your health care center_____

Out of average occupancy, the number of Medicaid residents _____

Out of average occupancy, the number of Medicare residents _____

Do you make a donation to your local community in lieu of property taxes? _____ Amount_____ 4

VII. Legislative Information

Indiana State Legislature Information:

Indiana State Legislative Districts **of the facility**: House # _____ Senate # _____

If not known, names of Indiana State Senator and Representative:

State Senator _____ State Representative _____

Are you ***personally*** well acquainted with any state representative/senator? _____

If so, who? _____ (May or may not be in your district)

Describe your relationship_____

_____

Please return form to:

LeadingAge Indiana

P.O. Box 68829

Indianapolis, IN 46268-0829

317-733-2380