

ASSISTED LIVING SERVICE ORGANIZATION

MISSION STATEMENT: To exist as a nonprofit organization to represent licensed residential care homes, their operators and owners, residents and concerned parties involved with residential care homes. To improve care, provide training and education, network resources, provide input for regulations and coordinate efforts with national, state and local authorities for improved communication and understanding of concerns.

*Thank you for being involved.
Your commitment to improve the care in residential homes
is supported through this Association.*

Dues Structure (please check one). Membership term is January – December each year. Make checks payable to the **ASSISTED LIVING SERVICE ORGANIZATION, P.O. Box 11416, Albuquerque, NM 87192-1416**

- \$100.00 per year minimum up to 10 beds, then \$10.00 per bed up to 35 beds
Sustaining Member - Administrators/Owners of licensed homes or health related businesses.
- Flat Yearly Rate \$350.00 (36 beds or more)
Sustaining Member - Administrators/Owners of licensed homes or health related businesses.
- \$15.00 per year - Affiliated Member - Family members, friends or residents of licensed homes.

Date of Application _____ Date Approved _____ Membership No. _____

Corporate Name _____

Owner's Name _____

Mailing Address _____

Phone _____ Fax Number _____ E-Mail Address _____

Administrator's Name _____

Locations of Each Home:

Name of Home _____

Street Address _____

Phone _____ Fax Number _____

License Number _____ Number of Clients _____

Name of Home _____

Street Address _____

Phone _____ Fax Number _____

License Number _____ Number of Clients _____

Name of Home _____

Street Address _____

Phone _____ Fax Number _____

License Number _____ Number of Clients _____

The Association has established the following committees to meet the needs of the Association. If you are interested in serving on any of these committees please check one.

Compliance and Certification

Training

Membership

Legislation/Regulation

As part of this application please complete the following information. This information will be used to develop a referral data base for residential programs that are members of this Association. Please send a photograph of the outside of each home along with a copy of your license. Please include any written brochure or literature that you have on your program for our files.

Program Description and Services (use one form for each location)

Name/Address of Home _____

_____ Phone Number _____ Fax Number _____

Are you a current member Yes No License Number _____ Exp. Date _____ License Capacity _____

Do you accept Male Clients? Yes No Do you accept Female Clients? Yes No

Do you provide the following services?

(Check the ones that are provided as part of the daily/monthly rate or indicate if an additional fee is charged.)

Laundry _____

Community Outings _____

In-house Recreation Activities _____

Transportation _____

Dietary Restrictions _____

Hair Care _____

Manicures/Pedicures _____

Assistance with Bathing _____

Assistance with Eating _____

Assistance with Toileting _____

Assistance with Ambulation _____

Assistance with Medications _____

Do you accept clients with incontinence? Yes No

Do you accept clients that are wheelchair bound? Yes No

Do you accept clients that are combative? Yes No

Do you specialize in any type of care level?

Alzheimer Frail Elderly Hospice

Mental Health Physically Disabled

Are you licensed as a special program under the State Licensing Regulations? If so, name of program specialty.

Do you have an assessment process for admission? _____

Explain your staffing patterns:

Day Shift _____

Night Shift _____ (indicate if you provide assistance at night)

Additional Staff _____

Check your estimated monthly price range:

- Under \$1,000.00
- Between \$1,000.00 and \$1,250.00
- Between \$1,250.00 and \$1,500.00
- Between \$1,500.00 and \$1,800.00
- Above \$1,800.00

Signature of Applicant