



Membership Application Home and Community Based Services

Membership dues will be billed for the following program under a joint membership plan of LeadingAge New York and LeadingAge unless otherwise noted.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

General Information

Program Name: _____

Chief Executive Officer Name and Email: _____

Director and Email: _____

Address: _____

City/State/Zip: _____ County: _____

Phone: _____ Fax: _____ *Web Address: _____

Web Address: _____

**Most of LeadingAge New York's information is sent via e-mail, so please indicate the e-mail address where you would like to receive information in a timely manner.*

**Cell phones are used during conference by LeadingAge and LeadingAge New York to share information and updates.*

Type of Sponsorship (please check all that apply):

- Religious
- Governmental
- Other (please specify): _____
- Private Foundation
- Fraternal
- Community
- Union

Name of Sponsor: _____

Have you ever been a member of LeadingAge New York? Yes No

Type of Program: Please list total program revenue, line 9 form 990 for each type of program applicable:

- CHHA - Certified Home Health Agency _____
- Hospice _____
- LHCSA - Licensed Home Care Services Agency _____
- LTHHCP - Long Term Home Health Care Program _____
- NORC/NNORC/NORC-SSP- Naturally Occurring Retirement Communities _____
- NHTD Medicaid Waiver – Nursing Home Transition Diversion Waiver _____
- SADS - Social Adult Day Services _____
- TBI – Traumatic Brain Injury Medicaid Waiver _____

Other: (please list) _____