



NEW MEXICO • ALSO

Membership Application

Provider Member: A licensed assisted living community/residence
 Member Information: Please print or type below, your company's contact information.
 The contact person will receive New Mexico ALSO mailings (generally the Executive Director/Owner.)

Dues Structure (please check one): Membership term is January – December and is automatically renewed.
 Make checks payable to: A.L.S.O. 5500 San Mateo Blvd., NE Suite 114, Albuquerque, NM 87109

- \$100.00 per year minimum up to 10 beds, then \$10.00 per bed up to 35 beds. (Each bed owned by the same business, must be included in the "per bed" count)
- \$350.00 flat yearly rate (36 beds or more)

****If Joining after January, call the office for your pro-rated amount due****

Date of Application _____

Facility/Community/Service Provider: _____ # of beds: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Email: _____ Website: _____

If more than one location, please attach list of locations including # of beds for each location

CEO and/or Administrator (Main Point of Contact)

Name: _____ Title: _____

(complete below only if different from above)

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Email: _____ Website: _____

Billing Contact (complete only if different from above)

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Email: _____ Website: _____

Is billing contact part of a multiple campus facility/corporation? Yes No Name of Corporation: _____

As a NM ALSO member, you will receive all our mailings and services including the NM ALSO newsletter, a listing on our website, timely Assisted Living news and policy alerts, training and education programs, annual Conferences, discounted Assistance with Medication testing and Transportation testing.

The Association has established the following committees to meet the needs of all Assisted Living Providers in New Mexico. If you are interested in serving on any of these committees, please check one:

- Education & Training Public Relations Legislation/Regulation Membership

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 if services differ)

Name/Address of Home: _____

License #: _____ Exp. Date: _____ License Capacity: _____

Phone: _____ Fax: _____

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 Included Additional fee charged Not offered
- Outings Included Additional fee charged Not offered
- In-House Activities Included Additional fee charged Not offered
- Transportation Included Additional fee charged Not offered
- Dietary Restrictions Included Additional fee charged Not offered
- Hair Care Included Additional fee charged Not offered
- Manicures/Pedicures Included Additional fee charged Not offered
- Assistance with Bathing Included Additional fee charged Not offered
- Assistance with Eating Included Additional fee charged Not offered
- Assistance with Toileting Included Additional fee charged Not offered
- Assistance with Ambulation Included Additional fee charged Not offered
- Assistance with Medications Included Additional fee charged Not offered

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's Dementia Mental Health Hospice
 Frail Elderly Physically Disabled

Are you a Coordination of Long Term Services Provider (CoLTS, formerly D&E) ?

If so, do you contract with the following: Amerigroup Evercare

Do you have an assessment process for admission? Yes No

Explain your staffing patterns:

Day Shift: _____ Night Shift: _____ Is night staff awake? Yes No

Additional Staff: _____

Check your estimated monthly price range:

- Between \$1500 - \$2000 Between \$2000 - \$2500 Between \$2500 - \$3000 Between \$3000 - \$3500 Above \$3500

Signature of Applicant