



# Aging Services of Minnesota

LEADING CHANGE ■ CHANGING LIVES

## Business Partner Membership Application

Organization \_\_\_\_\_

Primary Contact \_\_\_\_\_

Title \_\_\_\_\_

E-mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip+4 \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Web site \_\_\_\_\_

### Type of Ownership

- Public       Non-profit       Corporation  
for Public       Other  
proprietary

### Geographic scope of your market

- State       Regional       National

What is your primary interest in an Aging Services membership?

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Describe your products or services \_\_\_\_\_

*Please include appropriate **category** and **keywords** for the Aging Services Buyer's Guide and online listing*

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Other contacts from your organization:

1) \_\_\_\_\_

Name

Title

E-mail \_\_\_\_\_

2) \_\_\_\_\_

Name

Title

E-mail \_\_\_\_\_

How did you hear about Aging Services of Minnesota?

\_\_\_\_\_  
\_\_\_\_\_

*I understand that membership is conditional upon approval by the Aging Services of Minnesota Board of Directors and that before becoming a member I must remit the necessary dues.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

This category of membership provides the same privileges of voting membership, excluding the ability to vote, hold office or serve as a Director.

**FOR AGING SERVICES USE**

Application/Dues Received \_\_\_\_\_

Dues Payment Processed \_\_\_\_\_

Application Processed \_\_\_\_\_

**METHOD OF PAYMENT**

**Amount** \_\_\_\_\_

**Check #** \_\_\_\_\_

*Make checks payable to Aging Services*

**Card #** \_\_\_\_\_

**Exp. Date** \_\_\_\_\_

**Name on Card**

X \_\_\_\_\_

**Cardholder Signature**



*Please submit application and dues to:*

**Aging Services of Minnesota**  
**2550 University Avenue West, Suite 350-South**  
**Saint Paul, MN 55114-1900**