Aging Services of Minnesota
LEADING CHANGE ■ CHANGING LIVES
Formerly Minnesota Health & Housing Alliance

Voting Not-For-Profit Care Center Membership Application

Facility ____

Administrator____

Address ____

City ______________________________ State _______ Zip+4 _______________

Phone ___________________________ Fax ______________________________

E-mail ____

Web site ____

County ___________________________

Bed Information:

______ Active Beds ______ Beds on layaway ______ Rehab

______ Dementia ______ Hospice ______ **TOTAL BEDS**

Notes:

____

Director of Nursing:

____
Name
E-mail____

Other contacts from your organization:

1) ____

Name *Title*

E-mail____

2) ____

Name *Title*

E-mail____

How did you hear about Aging Services?

____

What are your primary interests in Aging Services membership?

____

____

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 voting and office holding privileges. For prospective members that are part of a multi-facility organization, all eligible facilities of that organization shall be members of Aging Services of Minnesota.

METHOD OF PAYMENT

Amount ______________

Check # ______________

Make checks payable to Aging Services of MN

Card # ______________________

Exp. Date ______________

____

Name on Card

X______________________________

Cardholder Signature

FOR AGING SERVICES USE

Application/Dues Received _______

Dues Payment Processed _______

Application Processed _________

Please submit application and dues to:

Aging Services of Minnesota
2550 University Avenue West, Suite 350-South
Saint Paul, MN 55114-1900
651.645.0002 (FAX)