LeadingAge New Jersey

On Mission, Serving New Jersey's Seniors

PROVIDER MEMBERSHIP APPLICATION

Facility Name _____

Address _____

_____ _____ _____

Phone # Fax # Website Address

Primary Contact Person & Title _____

Email Address: _____

Check Type of Sponsorship

Community _____ Governmental _____

Private _____ Religious _____

Fraternal _____ *(please note denomination)* _____

Corporate Sponsor, if any _____

Management Company, if any _____

Note # of licensed beds/units (include all that apply)

_____ Assisted Living _____ Nursing Home

_____ Class C Boarding Home _____ Residential Health Care

_____ Comprehensive Personal Care _____ Subsidized Housing

_____ Independent Housing

Note # of Medicaid/Medicare beds _____ Medicaid _____Medicare

Is your facility under development? Yes No

If yes, estimated date of completion _____

Is your facility a Life Plan Community (CCRC) ? Yes No

Please note the year your facility opened: _____

If facility is federally funded, specify source (e.g. Section 202, 236) _____

The Provider hereby agrees to operate within the attached code of ethics

_____ _____

Signature Date

_____

Name & Title *[Please Print]*

Return the signed application with a copy of your facility's **nonprofit tax classification – 501(c)3** and a copy of either your most recent **IRS Form 990**, **Audited Financial Statement**, or **Facility Cost Medicaid Report**

to: LeadingAge New Jersey
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