

Missouri Assisted Living Association  
2407B Hyde Park Road, Jefferson City, MO 65109  
Phone: (573) 635-8750 Fax: (573) 634-7344

**FACILITY MEMBERSHIP APPLICATION**

**All fields MUST be completed**

**Facility Information**

Facility Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_  
Mailing Address (if different): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**DHSS Region - Refer to map on reverse side of application:**

Region 1    Region 2    Region 3    Region 4    Region 5    Region 6    Region 7

**Contact Information**

Owner's Name: \_\_\_\_\_  
Administrator: \_\_\_\_\_ Alternate Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Email:** \_\_\_\_\_ **Website:** \_\_\_\_\_  
(use the Comment section for additional email addresses)

**Facility Licensure by Department of Health & Senior Services:**

\_\_\_\_\_ Residential Care Facility (formerly RCF I)   \_\_\_\_\_ Residential Care Facility (formerly RCF II)  
\_\_\_\_\_ Assisted Living Facility (ALF)   \_\_\_\_\_ ALF- Accepts Those Requiring More than Minimal Assistance (ALF\*\*)

**Are you also licensed by the Department of Mental Health? YES or NO**

Required if 50% or more of residents have a mental illness diagnosis or one resident or more with a mental retardation diagnosis.

**Do you participate in the Personal Care Program (Medicaid)? YES or NO**

**Annual Membership Dues**

**General Members:** For persons/entities owning less than five (5) licensed facilities in Missouri:

Number of DHSS Licensed Beds: \_\_\_\_\_ x \$6 = \_\_\_\_\_ plus \$150 base rate = \$\_\_\_\_\_ (not to exceed grand total of \$650)

**Corporate Members:** For persons/entities owning five (5) or more licensed facilities in Missouri:

Number of DHSS Licensed Beds: \_\_\_\_\_ x \$4 = \_\_\_\_\_ plus \$1,000 base rate = \$\_\_\_\_\_ (not to exceed grand total of \$10,000)

**Payment Method**

\_\_\_\_\_ Check enclosed (payable to MALA)   \_\_\_\_\_ Credit Card (circle): VISA or MasterCard

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

**How did you hear about MALA?** \_\_\_\_\_

**Comments:** \_\_\_\_\_  
\_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Form must be signed)

NOTE: Membership is for ONE YEAR from the date of receiving this application and payment of dues.

**Upon completion, please return this form with payment to the above address. Fax is acceptable only if paying by credit card.**



**Division of Regulation and Licensure**  
**Section for Long Term Care Regulation**  
3418 Knipp Drive, Suite F  
P.O. Box 570  
Jefferson City, MO 65102-0570  
(573) 526-8524  
Fax: (573) 751-8493

## Long Term Care Regions

