

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

FACILITY MEMBERSHIP APPLICATION

Facility Information - ***If more than one facility is owned, but less than five total, please complete a form for each facility.*

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

DHSS Region - Refer to map included:

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:** _____

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) per facility

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 or Discover

Credit Card Number: _____ Exp Date: _____

3-Digit Security Code (on back of card): _____

Cardholder's Signature: _____

How did you hear about MALA? _____

****MALA by-law change effective May 1, 2012. *All facilities enjoined by common ownership/identity of interest of a member facility must also be members.*** Active members may consist of any facility or other legal entity which is specifically licensed to do business as an ALF or RCF in the State of Missouri.

Authorized Signature: _____ **Date:** _____

(Form must be signed)

NOTE: Membership is for ONE YEAR. Expiration date(s) will be on the last day of the month in which the membership dues are received.

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
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Long Term Care Regions

