2019 Provider Membership Application

For a company/individual who owns/operates an assisted living facility.
Please fill out completely. Type or print in blue or black ink only.

Corporate Company Information (if applicable) For facility information fill out form on back. ⟹

Company Name					
Mailing Address					
City		State		Zip	
Phone		Fax			
County					
Website					
Primary Contact for WALA					
Title					
*Email					
Reason You Are Joining WALA:					
How Did You Hear About WALA:					
Add a 75 word description of your facility through the Members Only area at www.ewala.org or attached to this application.					

**By giving WALA your email you are opting-in for email communications. All information above will be posted on www.ewala.org as a member benefit. Please contact the WALA office to opt out.*

Number of Facilities	
Total Number of Beds	

Payment Plans—Choose One	
A	1 payment at $21.00/bed or apt.
B	2 payments at $12.50/bed or apt.
C	4 payments at $6.25/bed or apt.
Email Info/Invoices/Notices	
Mail Info/Invoices/Notices	

Payment of Dues: *Select a payment method. Don't forget to include your payment with this form!*		
Total Amount Due: *Multiply total beds by payment plan amount.*		$
☐ Cash ☐ Check ☐ Credit Card *(MasterCard, Visa, Discover, or American Express)*		
Number	CVV	Expires
Signature		
I agree that WALA may charge my credit card in the amount shown. WALA dues are non-deductible as a charitable contribution and 4% of WALA dues are a non-deductible business expense due to lobbying activities.		

WALA – Wisconsin Assisted Living Association
P.O. Box 7730 – Madison, WI 53707-7730
Phone: 608/288-0246 Fax: 608/288-0734 info@ewala.org www.ewala.org

Rev. 7/2018

ARGENTUM
EXPANDING SENIOR LIVING
STATE PARTNER

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Please fill out completely. Type or print in blue or black ink only.

Facility Information

Please fill out for each facility.

Facility Name (or as it appears on license)					
Address					
City		State		Zip	
Phone		Fax			
County					
Facility Contact					
Title					
BAL License Number		Date License Issued			

Add a 75 word description of your facility through the Members Only area at www.ewala.org or attached to this application.

Number of Beds	

Type of Facility			
	AFH		
	CBRF		
	RCAC	☐	Registered
		☐	Certified

Licensing Information—As licensed by the Bureau of Assisted Living			
	Advanced Aged		Persons with AIDS
	Alcohol or Drug Dependent		Physically Disabled
	Correctional Clients		Pregnant Women/Counseling
	Developmentally Disabled		Terminally Ill
	Emotionally Disturbed/Mental Illness		Traumatic Brain Injury
	Alzheimer's and Dementia		

Other Contacts

Contact Name	
Title	
*Email	

Contact Name	
Title	
*Email	

Contact Name	
Title	
*Email	

Contact Name	
Title	
*Email	

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