



Aged & Community Services
Association of NSW & ACT

AGED & COMMUNITY SERVICES ASSOCIATION OF NSW & ACT INC.

APPLICATION FOR MEMBERSHIP

NAME OF APPLICANT: _____

(i.e. the name under which the applicant organisation is registered with the Australian Tax Office as a Group Employer)

STREET ADDRESS: _____

_____ P/CODE: _____

POSTAL ADDRESS: _____

(If same as street address print "as above")

_____ P/CODE: _____

PHONE NUMBER: _____

FAX NUMBER: _____

EMAIL ADDRESS: _____

WEBSITE: _____

ABN: _____

NATURE OF ORGANISATION: (Please tick where appropriate)

- | | | | |
|-----------------------------------|--------------------------|--------------------------------|--------------------------|
| Incorporated under Companies Code | <input type="checkbox"/> | Associations Incorporation Act | <input type="checkbox"/> |
| Church Organisation | <input type="checkbox"/> | Community Group | <input type="checkbox"/> |
| Local Government | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| State Government | <input type="checkbox"/> | | |

N.B. PLEASE ENCLOSE A COPY OF YOUR CONSTITUTION/RULES OR MEMORANDUM AND ARTICLES OF ASSOCIATION. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT IT.

BOARD/COMMITTEE OF MANAGEMENT:

Official Title: _____

(i.e. Board of Management/Management Committee/Council/Trustees etc.)

Name of *Chairman/President: _____

(* Delete as appropriate)

CHIEF EXECUTIVE OFFICER:

Name: _____

Title: _____

Address: _____

Phone Number: _____

Mobile: _____

Fax Number: _____

Email Address: _____



SERVICES TO BE REGISTERED UNDER THIS MEMBERSHIP

RESIDENTIAL CARE FACILITIES:

Facility Details:

1. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Type of Facility: _____ Number of Beds: _____
(High Care/Low Care/Self Care)

2. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Type of Facility: _____ Number of Beds: _____
(High Care/Low Care/Self Care)

3. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Type of Facility: _____ Number of Beds: _____
(High Care/Low Care/Self Care)

4. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Type of Facility: _____ Number of Beds: _____
(High Care/Low Care/Self Care)

(N.B. If space is insufficient, please add extra page/s)



COMMUNITY AGED CARE PACKAGES/EACH PACKAGES:

CACP/EACH/EACHD Details:

1. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Number of CACP/EACH/EACHD: _____
(Please circle)

2. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Number of CACP/EACH/EACHD: _____
(Please circle)

3. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Number of CACP/EACH/EACHD: _____
(Please circle)

4. Name: _____
Address: _____

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address: _____
Number of CACP/EACH/EACHD: _____
(Please circle)

(N.B. If space is insufficient, please add extra page/s)



COMMUNITY CARE SERVICES:

Service Details:

1. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other
Other:
Average Number of Clients:
Amount of Recurrent Funding:
Name:
Address:

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address _____

2. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other
Other:
Average Number of Clients:
Amount of Recurrent Funding:
Name:
Address:

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address _____

3. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other
Other:
Average Number of Clients:
Amount of Recurrent Funding:
Name:
Address:

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address _____

4. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other
Other:
Average Number of Clients:
Amount of Recurrent Funding:
Name:
Address:

Contact Person: _____ Title: _____
Phone Number: _____
Fax Number: _____
Email Address _____

(N.B. If space is insufficient, please add extra page/s)



Aged & Community Services
Association of NSW & ACT

CERTIFICATIONS:

I/we certify that:

1. I/we have read and fully appreciate the ACS Statement of Philosophy received with this application.
2. I/we have received and read a copy of the current Constitution and Rules of the Aged & Community Services Association of NSW & ACT Inc and understand the rights, privileges and obligations of members of the Association.
3. The income and property of the applicant organisation whencesoever derived, shall be applied solely towards the promotion of the objects of the organisation and no portion thereof shall be paid or transferred either directly or indirectly, by way of dividend, bonus or otherwise, to members of the organisation.
4. The information given herein is true and correct in every particular and I/we undertake to inform the Association promptly in the event of any change in particulars.

Pursuant to a resolution of the
Board/Committee of Management of the

.....
(Name of applicant organisation)

I/we hereby apply for membership of the Aged & Community Services Association of NSW & ACT Inc and agree to comply with its Constitution, Rules and By-laws as from time to time in force.

Signed:..... Date:.....
(Chairman)

Signed:..... Date:.....
(Secretary)

! Have you attached your constitution/rules to this membership application form?

NOTES – FEES & SUBSCRIPTIONS:

An invoice for the rateable proportion of annual fees and subscriptions due in respect to your organisation's membership of the Association for the current year will be forwarded to you together with confirmation of acceptance of your application for membership.

Aged & Community Services Association of NSW & ACT Inc.
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RHODES NSW 2138
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Email: mail@agedservices.asn.au