

MCKNIGHT'S ASSISTED LIVING, 114 W. 26TH ST., NEW YORK, NY, 10001, TELEPHONE: (646) 638-6000, FAX: (646) 638-6114

Do you wish to receive a FREE subscription to McKnight's Assisted Living magazine?

Yes  No

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

J6OFFICE

**FAX FORM TO (646) 638-6114 OR MAIL TO THE ADDRESS ABOVE.  
ALL QUESTIONS MUST BE ANSWERED.  
Subscriptions subject to publisher's approval.**

**1. What is your facility's type of business?**

- 01 Assisted Living Facility  
 02 Continuing Care Retirement Community (CCRC)  
 03 Independent Living Facilities  
 04 Alzheimer's Facilities and Dementia Facilities  
 05 Assisted Living with Alzheimer's Care  
 20 Construction and Development  
 30 Architecture and Design Firms  
 99 Other (please specify) \_\_\_\_\_

**2. What is your title? (check only one)**

- 01 CEO, CFO, COO, President, VP, Owner (Corporate Mgmt)  
 02 Administrator/Executive Director  
 03 Director of Nursing  
 04 Administrator  
 05 Sales and Marketing Director  
 06 Activities Director  
 99 Other (please specify) \_\_\_\_\_

**3. What is your facility's bed size? (Check only one)**

- 01 Less than 50  04 200-299  
 02 50-99  05 300 +  
 03 100-199

**4. Which of the following services does your facility provide?**

(Check all that apply)

- 01 Assisted Living  
 02 Home Care Service  
 03 Visiting Nurse Services  
 04 Companion Services  
 05 Alzheimer or Dementia Care  
 06 Skilled Nursing  
 07 None of the above

**5. Are you a member of? (Check all that apply)**

- 20 ALFA  
 21 NCAL  
 22 Neither

**6. Is your facility?**

- 01 For profit  
 02 Non-profit

**7. Is your facility?**

- 01 Independently Owned  
 02 Chain affiliated

**8. What percentage of your revenue is: (Total should equal 100%)**

- 01 Private Pay \_\_\_\_\_%  02 Medicaid \_\_\_\_\_%