



## State Society on Aging of New York

Founded in 1972 as the New York State Association of Gerontological Educators (NYSAGE)

[www.ssany.org](http://www.ssany.org)

### 2019 MEMBERSHIP APPLICATION FORM

(Membership Term: January 2019 – December 2019)

**Membership Types: Please select one and complete additional information on the reverse side of this page.**

**( ) Organization: \$75 per year**

Organizations are entitled to designate two voting members (and two free student memberships) who will receive the SSA newsletter, membership directory, and a discounted rate for the annual conference. The organization will also receive a free ¼ page ad in the annual conference program book.

**( ) Professional: \$40 per year**

Each professional member is a full voting member of the SSA, receives the SSA newsletter and membership directory and is entitled to a discounted rate for the annual conference.

**( ) Student: \$15 per year**

Each graduate or undergraduate student enrolled at least half time is a voting member of the Student Committee, receives the SSA newsletter and membership directory, and is entitled to a discounted rate for the annual conference.

**( ) Senior: \$15 per year**

Those age 65 years or older will receive the same benefits as the professional membership type.

Member 1	Member 2 (if organization membership)	Student's Name (if organization membership)
Name	Name	Name
Title	Title	Address
Organization	Organization	University Name & Email
Address	Address	<b>Student's Name (if organization membership)</b>
City, State, Zip	City, State, Zip	Name
Email	Email	Address
Tel/Fax	Tel/Fax	University Name & Email

( ) I was referred by SSA Member: \_\_\_\_\_

**Please make your check payable to "State Society on Aging" and mail your completed application to:**

Janna Heyman, SSA Board Member  
 c/o Fordham University Graduate School of Social Service  
 400 Westchester Avenue, West Harrison, NY 10604

**FOR OFFICE USE ONLY**

(send copy to Membership Committee)

\_\_\_ Renewal Membership

\_\_\_ New Membership

\_\_\_\_\_ Date payment received

\$ \_\_\_\_\_ Amount Paid

Signature, Treasurer \_\_\_\_\_

**SSA Membership Application (continued)**

**Member's Name:** \_\_\_\_\_

**Please review and check appropriate boxes so that we can maximize your SSA Membership Benefits:**

If **Professional Membership**, please check most appropriate category:

Psych    Social Work    Nursing    Physical Therapy    MD    Other: \_\_\_\_\_

**Type of Organization:**

Hospital    Home Care    Nursing Home    OPD/Clinic    Senior Center    Social/Adult Day Care  
Government    University    Other: \_\_\_\_\_

**Please check if interested in learning about or participating in one or more of the following standing committees:**

- |  |   |
|--|---|
| <input type="checkbox"/> Awards                    | <input type="checkbox"/> Social Policy            |
| <input type="checkbox"/> Budget/Finance            | <input type="checkbox"/> Membership               |
| <input type="checkbox"/> Education                 | <input type="checkbox"/> Nominations              |
| <input type="checkbox"/> Program                   | <input type="checkbox"/> Publications             |
| <input type="checkbox"/> Student Committee         | <input type="checkbox"/> Planning and Development |
| <input type="checkbox"/> Electronic Communications | <input type="checkbox"/> Committees & Standards   |

**Areas of Interest:**

- |  |   |
|--|---|
| <input type="checkbox"/> Community Services            | <input type="checkbox"/> Education              |
| <input type="checkbox"/> Healthcare/Disease Management | <input type="checkbox"/> Income Security        |
| <input type="checkbox"/> Long Term Care                | <input type="checkbox"/> Minority               |
| <input type="checkbox"/> Nursing Homes                 | <input type="checkbox"/> Public Policy          |
| <input type="checkbox"/> Retirement                    | <input type="checkbox"/> Senior Center          |
| <input type="checkbox"/> Wellness                      | <input type="checkbox"/> Home Care              |
| <input type="checkbox"/> Rehabilitation Therapy        | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Mental Health                 | <input type="checkbox"/> Other: _____           |

Please sign **ONLY** if you do not wish your name in the directory:

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