NYSHFA | NYSCAL

ASSOCIATE MEMBER APPLICATION

Organization Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Website: _____

Organization Representative: _____ Email: _____

Title/Position: _____ Phone: _____

PLEASE PROVIDE A BUSINESS REFERENCE:

Organization Name: _____

Contact Person: _____ Phone: _____

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR COMPANY AND THE SERVICES PROVIDED:

Please include a copy of most recent Annual Report or copies of promotional materials

ASSOCIATE MEMBER DUES STRUCTURE: (CHECK ONE)

☐ $1,200.00 - Annual Membership (January - December)

☐ $925.00 - Pro-Rated (Applications received after July 1st, covers through December 31st)

METHOD OF PAYMENT

☐ Check (Payable to NYSHFA)

☐ AMEX ☐ Discover

☐ MasterCard ☐ Visa

MAIL PAYMENTS TO: NYSHFA | NYSCAL- Associate Member Program
33 Elk Street, Suite 300,
Albany, NY 12207

Credit Card Number: | Exp. Date:

Cardholder Name:

Billing Address:

Authorized Cardholder Signature:

The above named organization hereby makes application for Associate Membership in the New York State Health Association, Inc. (NYSHFA) | New York State Center for Assisted Living (NYSCAL) and agrees, if accepted, to support the Association's goals and objectives. The organization agrees to pay established dues in a timely manner.

Signature: _____ Print Name: _____ Date: _____

For More Information, Please Contact the NYSHFA | NYSCAL Communication Department - 518.462.4800 ext 23

NYSHFA NYS HEALTH FACILITIES ASSOCIATION | NYSCAL NYS CENTER FOR ASSISTED LIVING

NYSHFA-NYSCAL.ORG