FOUNDATION *for* QUALITY CARE

NYSHFA | NYSCAL

2025

PLATINUM SPONSORSHIP APPLICATION

☐ I am a current Platinum Sponsor ☐ I am a current Associate Member

Organization Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Website: _____

Organization Representative: _____ Email: _____

Title/Position: _____ Phone: _____

BUSINESS TYPE: (PLEASE CHECK ONE)

☐ Pharmacy ☐ Reimbursement Specialists

☐ Financial Management / Accounting ☐ Technology / EMR Services

☐ Business Consulting / Management Resources ☐ Therapy Services

☐ Medical Supply / DME ☐ Compliance / Other _____

PLATINUM SPONSORSHIP PAYMENT

— $12,500 Due Upon Submission of Completed Platinum Sponsorship Package Application —

— Sponsorship will be Effective for 12 Months —

METHOD OF PAYMENT

☐ Check (Payable to NYSHFA)

☐ AMEX ☐ Discover

☐ MasterCard ☐ Visa

MAIL PAYMENTS TO: NYSHFA | NYSCAL – The Platinum Sponsorship
33 Elk Street - Suite 300
Albany, New York 12207

Credit Card Number: | Exp. Date:

Cardholder Name:

Billing Address:

Authorized Cardholder Signature:

The above named organization hereby makes application for The Platinum Membership Package 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.

Signature: _____ Print Name: _____ Date: _____

For more information, please contact Laura Greenaway at 518.462.4800 ext. 27 or lgreenaway@nyshfa-nyscal.org

NYSHFA-NYSCAL.ORG