



**VIRGINIA
HEALTH CARE
FOUNDATION**

Donation Form

Mail completed form to the above address.

Please help us make health care a reality for more uninsured Virginians today!

CONTACT INFORMATION:

Name *(as you wish it to appear in VHCF publications)* _____

Address _____

City _____ State ____ Zip _____

Phone *(day)* _____ *(evening)* _____ E-mail _____

(Thank you for providing this information, so we may contact you if a clarification is needed in processing your donation.)

GIFT AMOUNT & PAYMENT METHOD:

Gift amount \$ _____

Check enclosed *(payable to VHCF)*.

Credit Card - select one: _____ MasterCard _____ Visa _____ American Express

Credit Card # _____ Exp. Date ____ / ____ CCV _____

Name on card _____ Signature _____

I/we would like to provide ongoing support. Please charge my credit card \$ _____ per month until _____.

PLEASE APPLY MY GIFT:

_____ To the area of greatest need.

_____ To provide Rx medicines to the uninsured.

_____ To help expand Virginia's dental safety net.

_____ To increase access to mental health services.

_____ To help newly eligible Virginians apply for state health coverage.

MY CONTRIBUTION IS MADE:

In honor of _____

In memory of _____

Relationship to donor _____

Please send an acknowledgement of my gift to:

Name _____

Address _____

City _____ State ____ Zip _____

ADDITIONAL INSTRUCTIONS:

_____ I have enclosed my employer's matching gift form.

_____ My gift has been pre-approved to receive State Neighborhood Assistance Program (NAP) credits.

_____ I plan to give a gift of stock.

_____ I would like to include VHCF in my will.

Thank you for your contribution!

Your gift is tax deductible. For more information, call (804) 828-5804.