707 East Main Street, Suite 1350 • Richmond, VA 23219 • **www.vhcf.org**
Phone: (804) 828-5804 • Fax: (804) 828-4370 • email: kimberlys@vhcf.org

Donation Form

Mail completed form to the above address.

Be Part of the Solution for Uninsured Virginians!

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 provide medical care to the growing number of uninsured Virginians.
_____To help newly eligible Virginians apply for state health coverage.
_____To increase access to mental health services.
_____To provide Rx medicines to the uninsured.
_____To the area of greatest need.

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.