VIRGINIA HEALTH CARE FOUNDATION

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 the completed form to the address above.

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 clarification is needed in processing your donation.)

GIFT AMOUNT & PAYMENT METHOD:

Gift amount $ _____

- ☐ Check enclosed (*payable to VHCF*).
- ☐ This is a pledge payable by June 30, 2025.
- ☐ I would like to provide ongoing support. Please charge my credit card $_____ per month until _____ (*Month/Year*).
- ☐ Credit Card - select one: _____ MasterCard _____ Visa _____ American Express

Credit Card #_____Exp. Date_____/____CCV_____

Name on card_____Signature _____

PLEASE APPLY MY GIFT:

_____To increase Virginia's healthcare workforce.
_____To increase access to mental health services.
_____To help eligible Virginians apply for state health coverage.
_____To provide medical and dental care to uninsured Virginians.
_____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.
_____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. If you prefer to make a gift online, visit
https://www.vhcf.org/donate/donate-now/.
For more information, call Kimberly Separ at (804) 587-0515.