



VIRGINIA
HEALTH CARE
FOUNDATION

6806 Paragon Place, Suite 250 • Richmond, VA 23230 • www.vhcf.org
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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, 2026.
☐ 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, contact Kathryn Zapach at (804) 828-5801 or kathryn@vhcf.org.