



VIRGINIA  
**HEALTH CARE**  
FOUNDATION

## 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: \_\_\_\_\_ 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 (804) 828-5804 or [info@vhcf.org](mailto:info@vhcf.org).