Donation Form

cascade HEALTH FOUNDATION

Today's Date:_____

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Main Ph:_____ ☐ Hm ☐ Cell Work Ph:_____

Other Ph:_____ OK to leave detailed message? ☐ Yes ☐ No

Email:_____

I would like to make a donation to Cascade Health to be used for:

☐ General Fund (area of greatest need)
☐ Hospice
☐ Pete Moore Hospice House
☐ Diabetes & Nutrition Education

In the amount of:

☐ $10,000
☐ $1,000
☐ $100
☐ Other: $_____
☐ $5,000
☐ $500
☐ $50
☐ $2,500
☐ $250
☐ $25

My donation is in:

☐ Honor ☐ Memory of:_____
☐ Please notify:

Name(s):_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____

☐ I wish to remain anonymous in donor recognition materials.

Method of payment: ☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card number:_____ CVV:_____ Exp.:_____ Zip:_____

Name on card:_____ Signature:_____

Thank you for your gift! You will receive a donation receipt in the mail for tax purposes.