# DONATION FORM

Allina Health FOUNDATION

*Thank you for your generous gift to Allina Health Foundation.*
*Your donation directly contributes to the health, wellness and independence of patients & clients, their caregivers, and the communities we serve.*

## Donor Information

**Name(s)** _____
Print name exactly as you would like it to appear for acknowledgement.

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Phone** _____ **Email** _____

❑ Make my gift anonymous

## Donation Information

**Donation Designation -** *What area would you like your funds to benefit?*

❑ Where the Need is Greatest at Allina Health

❑ Other _____

**Donation Type**

❑ One-time gift

❑ Recurring monthly gift charged to the credit card below - *recurring monthly gifts are processed on the 15th of each month*

**Donation Amount $** _____

❑ check is enclosed - *make checks payable to Allina Health Foundation*

❑ charge the donation to a credit card - *provide information below*

Card # _____ Expiration _____ CVV _____

Signature _____

## Optional Tribute Information

This gift is ❑ in memory of OR ❑ in honor of

Name(s) _____

*If you would like us to send a notice of the tribute gift, provide the name and address of who should receive the notice. The donation amount is confidential.*

Name(s) _____

Address _____

City _____ State _____ Zip _____

**Send this completed form along with your gift to:**
Allina Health Foundation
2925 Chicago Ave Mail Route 10721
Minneapolis, MN 55407

AllinaHealthFoundation@allina.com
612-262-0635
allinahealth.org/give
EIN 27-4116873