



The purpose of this **Gift Agreement**, with the Hudson River HealthCare Foundation prepared on ____ / ____ /20____, is to summarize the mutual understanding between _____, and the HRHCare Foundation regarding your commitment to make a charitable donation. This agreement will be made a part of HRHCare Foundation's permanent records and is intended to serve as a guide to those who will administer these funds in the future.

BENEFACTOR INFORMATION

First and Last Name: _____ Birth Date: _____
 Spouse First and Last Name: _____ Birth Date: _____
 Name: _____
Primary Contact Information _____ Telephone: _____
 Address: _____ (Home) _____
 Email: _____ (Bus.) _____
 _____ (Cell) _____
Alternate Contact Information _____ Telephone: _____
 Address: _____

GIFT INFORMATION

1) Gift Amount \$ _____
 2) Gift Type
 CASH (Please make checks payable to **HRHCare Foundation**)
 STOCK
 ELECTRONIC TRANSFER
 PLEDGE: Pledges are entered upon receipt of this **Gift Agreement**. Payments are calculated based on the Gift Amount above and the Pledge Period indicated below.
 Pledge Period: 1 years 2 years 3 years
 Pledge Reminders: Quarterly Semi-Annually Annually
 CREDIT CARD Please charge my credit card:
 American Express Discover MasterCard Visa Amount \$ _____
 Automate Payments: Monthly Quarterly
 Name on Card: _____
 Billing address is same as above primary contact information
 Account number: _____ Expiration date: _____
 Authorized signature: _____ Sec. Code: _____

Please see other side.

GIFT MATCHING

My/Our gift will be matched by _____ company/foundation/family.

Match amount \$_____ Form enclosed Form will be forwarded

GIVING OPTIONS

- Annual Fund provides unrestricted funds where they are needed most.
- Capital Fund for facility and technology enhancements
- Early Cancer Detection Fund provides support for cancer and prevention programs
- Farmworker Health Fund provides health care for children and families of agricultural workers
- Fund A Need provides support for special projects
- Jeannette Phillips Heritage Scholarship Fund provides support for HRHCare staff and Peekskill youth interested in advancing or pursuing a career in health care.

IN MEMORY/HONOR

Please complete the information below regarding your donation in memory or in honor of your loved one.

1) Name you wish to memorialize or honor _____

2) Notification name & address

3) Public Salutation

Print name as you wish it to be displayed in opportunities for recognition.

Yes, you may use my name for publications and donor recognition displays.

No, we prefer not to be listed.

BENEFACTOR AGREEMENT SIGNATURE

Signature: _____

Signature: _____

Date: / /20__ HRHCare Foundation Representative: _____

Thank you for supporting HRHCare Foundation.