ALLUVION HEALTH FOUNDATION

MOBILE AUTISM CLINIC DONOR FORM

DONOR INFORMATION

(your personal information is kept confidential)

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____

CITY: _____ **ST:** _____ **ZIP:** _____

EMAIL/WEBSITE: _____

PHONE: (_____ **)** _____

☐ I would prefer that my donation and/or my name be kept confidential.

☐ Please mail my tax receipt.

CONTRIBUTION INFORMATION

(pledge levels on back side of page)

One Time Donation, in the amount of: **$** _____ , ***or***

Repeating Donation, as follows:

$ _____ **every:** -

Does your employer match donations? YES ☐ NO ☐

☐ Please make checks payable to Alluvion Health Foundation, 111 5th Ave North, Great Falls, MT 59401.

☐ Paying online at **https://alluvionhealth.org/foundation/**

☐ Please bill my credit card: -

Account Number: _____

Expiration: _____

To discuss charitable giving pathways that deliver overall community health, contact Teresa Schreiner at **406-231-6521** or **tschreiner@alluvionhealth.org.**

Pledges are conditional promises to give on behalf of the donor. The donor is not bound to this pledge until the payment is made. Thank you!

Alluvion Health Foundation is a Montana non-profit public charity with a 501(c)3 tax-exempt status from the IRS. Our EIN is 84-5066330. Donors can deduct contributions made to the Alluvion Health Foundation.

ALLUVION HEALTH FOUNDATION

MOBILE AUTISM CLINIC PLEDGE LEVELS

GOAL: $350,000

ALLUVION HEALTH FOUNDATION
111 5th Street North
Great Falls, MT 59401