DONATION FORM

*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