Hebrew HealthCare
A Hartford HealthCare Clinical Partner

Donation Form

*** Gift Amount: $ _____**

This Gift is: in honor / in memory of (circle one)**: _____**

Please Notify: _____

Mail Notification to: _____

***Name: _____**
As you wish to be listed in any print or electronic publications
☐ Please list me as Anonymous

*** Street Address: _____**

*** City/State/Zip: _____**

Phone: _____Email: _____
I would like to join your email list: ☐ Yes ☐ No

Payment Type: Cash **/** Check (*make checks out to Hebrew Health Care*)**/** Credit Card

*** Card Number: _____**

*** Exp. Date: _____** *** CVV Code: _____**

**must complete if paying with credit card*

Unless otherwise instructed, your gift will be directed to the area of greatest need and will provide an unrestricted gift that can be put to immediate use whenever it is needed most - including enhancing programs and services that lead to better care for all those we serve.

Please direct my gift to:

☐ Unrestricted (area of greatest need)
☐ Celebrate Life
☐ Endowment: _____
☐ Other: _____

For more information on giving opportunities please contact:

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