Hope Health Alliance, Inc.
DONATION PLEDGE FORM

The Hope Health Alliance and our Dignity Drop-in Center plays a critical role in filling gaps in services and developing community engagement around behavioral health and homelessness issues. Your support empowers our staff, volunteers, and members / clients by removing barriers to opportunity.

Let us know your pledge of support now, so we know we can count on you!
By making your pledge known now, you won't be solicited later in the year, saving Hope Health Alliance precious funds.

Name: _____

☐ **YES! Count on me for a donation to HHA!**

☐ **$50** ☐ **$100** ☐ **$500** ☐ **$1,000** **Other: $** _____

Payment Options:

☐ **Recurring Gift** (monthly, quarterly, annually)…. fill out form on back of sheet →

☐ **Check** (made payable to **Hope Health Alliance**)

☐ **Charge my credit card today** (for recurring gift options, see back)

☐

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Account Number: _____ Expiration Date: _____

Card Holder's Signature: _____ Security Code: _____

*New credit card security rules require your **exact billing address**, as linked to your credit card.*

OR, make your one time or recurring gift at: **hopeclinics.org/donations**

Return this form to Micole LaCounte at Hope Health Alliance
(micole@hopeclinics.org 1500 W. Broadway St., Ste. D, Missoula, MT 59808)

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Authorization for Credit Card / E-Check Donation Installments

I, _____, would like to make recurring payments to Hope Health Alliance's Annual Campaign in the amount of : $_____ **each month** on the

(circle one) ☐ 1st OR ☐ 15th of each month for

(circle one) ☐ until further notice OR ☐ 12 months for a total donation of $_____.

I authorize Hope Health Alliance to retain my credit card information for this purpose only.

Signature: _____ Date: _____

Donor Information

Last Name: _____ First Name: _____ MI: ___

Company Name: _____

Business Phone: _____ Home Phone: _____ Email: _____

☐ I wish to make my donations anonymously.

Special Notes:

_____

Billing Information / Attach a Voided Check for Banking Account Information

Name as it appears on the acct: _____

Card Type (circle one): ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Card Number: _____ Expiration Date: _____ Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Hope Health Alliance assures the confidentiality of this information.

If you have any questions, please contact Micole LaCounte, Executive Director at 541.500.9946 or micole@hopeclinics.org.

Hope Health Alliance is a nonprofit organization. Your donation is 100% tax-deductible.