ALLINA
HOME CARE, HOSPICE
& PALLIATIVE CARE
Allina Hospitals & Clinics

# Mail in Donation Form

Date of Gift: ____/____/____

Please check one & fill in name: ☐ Gift is in memory of _____

☐ Gift in is honor of _____

Please provide the following information for those you would like us to send a letter to informing them that a memorial gift on behalf of their loved one was made by you:

Name: _____

Address: _____

City, State, ZIP: _____

Please check which fund you would like your donation to support:

☐ General donation/ unrestricted ☐ Integrative Therapies
☐ TLC Fund ☐ Residential Hospice

Donor Name: _____

Address: _____

City, State, ZIP: _____

Day Phone: _____

Evening Phone: _____

Email: _____

☐ I have enclosed cash/ check.

☐ I would like to donate via credit card. Information below:

☐ VISA ☐MasterCard ☐Discover ☐American Express

Card Number: _____ Exp. _____

Amount of Gift: $_____

**If you are interested in making a gift of stock, please contact the Foundation Office at 651-241-5416.**

Please mail to: Allina Home Care, Hospice & Palliative Care Foundation
333 Smith Ave. N. – 60133
St. Paul, MN 55102