

## Make a Donation

Please complete this form to make a one-time or recurring gift.

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ email \_\_\_\_\_

**I would like to make a ONE-TIME GIFT TO VCCF in the amount of \$\_\_\_\_\_.**

Make check payable to Vashon Community Care Foundation and mail to VCCF, PO Box 2114, Vashon 98070

**I would like to become a SUSTAINING MEMBER OF VCCF with a monthly gift automatically deducted from my checking account.** Complete this form and mail to VCCF, PO Box 2114, Vashon 98070 with voided check and employer matching form, (if applicable.)

Account Holder Name (if different from the name above) \_\_\_\_\_  
first last

Start Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Monthly Payment Amount \$ \_\_\_\_\_

Bank \_\_\_\_\_ Branch \_\_\_\_\_

Routing No \_\_\_\_\_ Account No \_\_\_\_\_

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service provider and bank reasonable opportunity to act. (minimum 30 days)

All other changes such as payment amount, frequency, bank account number change, will require a new ACH Debit Payment Authorization form to be filled out and submitted to Vashon Community Care Foundation (VCCF) 15 days prior to any change being implemented. I understand that this payment plan may be canceled by the Service Provider or VCCF due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of \$25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and VCCF harmless from damages, loss or claim resulting from all authorized actions hereunder.

Account Holder Signature \_\_\_\_\_ Date \_\_\_\_\_

**A voided check from customer's bank account must accompany this authorization form.**

I request that my donation remain anonymous.

My employer will match my gift. (Please enclose matching form.)

In memory of \_\_\_\_\_

In honor of \_\_\_\_\_

Please notify the family or honoree of this gift.

Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Thank you for your gift.**