

Donor Letter

I / We are interested in supporting Our Lady of Hope Clinic’s mission to provide care to the uninsured of our community and would like to make a donation to the work of the clinic.

Our Lady of Hope Clinic is tax-exempt under section 501(c)(3) of the Internal Revenue Code in that the primary purpose of Our Lady of Hope Clinic is to serve the medical needs of individuals and families that cannot afford, or do not otherwise have access to, private health care coverage. A Letter of Determination has been requested.

I / We would like to support:

Our Lady of Hope Clinic general fund

\$_____ general donation

\$_____ monthly general donation - *Please fill out the Automatic Withdrawal Authorization Form on the back of this form (page 2) for automatic withdrawal.*

Sponsor an individual or family to receive benefactor services

Sponsorship allows an individual or family to become a benefactor by paying their benefactor fee. Please fill out a benefactor **Letter of Interest Form** to determine the correct benefactor donation.

\$_____ benefactor enrollment donation - *If you wish to support an individual or family directly, please provide their contact information:*

Name(s): _____

Contact Information: _____

Please mail your donation with this form to:

Our Lady of Hope Clinic
6425 Odana Rd,
Madison, WI 53719

Automatic Withdrawal:

If you would rather have your donation withdrawn from your bank account, please fill out the Automatic Withdrawal Authorization Form on the back of this page (page 2) and mail with this form to the above address.

Credit Card Payments:

Please see www.ourladyofhopeclinc.org PayPal DONATION logo for credit card donation.

Name(s) _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email address _____



6425 Odana Road • Madison, WI 53719 • (608) 819-8544

Dr. Anne Johnson
dranne@ourladyofhopeclinic.com

Dr. Michael Kloess
drmike@ourladyofhopeclinic.com

Automatic Withdrawal Authorization Form

This Automatic Monthly Withdrawal Form authorizes Our Lady of Hope Clinic Inc. (OLHC) to withdraw donations directly from the donor's bank account each month or annually. Please complete all three sections.

Part 1: Designation of Gift

General Fund designated donation to support OLHC and its mission
(Please include Donor Letter)
\$ monthly
\$ annually
(Choose monthly or annually)

AND/OR

Benefactor designated donation: -Enrollment 1 year annual payment
(Please include Letter of Interest) -Enrollment 1 year monthly payment [annual donation/12]
\$ annually
\$ monthly
(Choose monthly or annually)

Tax deductibility of donations governed by applicable state and federal tax law. Some portions of donations may not be deductible due to receipt of clinic services. Clinic will provide annual statements for tax purposes.

Part 2: Authorization for Automatic Monthly Withdrawal

Start Date: (mm/yy) ___/___ (withdrawals will be made on the first business day each month for Benefactor Services provided the following month)

Type of account: ___ Checking ___ Savings

Bank Name: _____

Routing # (9 Digits): _____

Account # : _____

Please attach a voided check to start automatic withdrawal from your checking account OR a deposit slip for a savings account.

Part 3: Contact Information

Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

AUTHORIZATION AGREEMENT FOR AUTOMATED WITHDRAWALS:

I hereby authorize and request OLHC to make monthly withdrawals in the amount listed above by initiating debit entries to my account indicated on the voided check copy provided, and I authorize and request BANK to accept my debit entries initiated by OLHC to such account. This authorization will remain in effect until I revoke authorization by writing to OLHC 10 days prior to my scheduled debit.

In the event that an automated banking withdrawal payment is denied, I agree to pay the monthly payment amount plus a \$20 service fee within 15 days. I understand that Our Lady of Hope Clinic will try to notify me of payment denial by phone and First Class mail. If the balance due is not paid within 15 days, I understand that my Benefactor Services will be discontinued. If discontinued, Benefactor Services may be restarted only at the discretion of Our Lady of Hope Clinic, and only upon full payment. Monthly automated banking withdrawal payments will not be offered to Benefactors or their immediate family with a history of two (2) automated banking withdrawal payment denials.

Return to:
Our Lady of Hope Clinic
6425 Odana Road
Madison, WI 53719

Signature: _____

Date: _____