



Dr. Anne Johnson  
dranne@ourladyofhopeclinic.com

Dr. Michael Kloess  
drmike@ourladyofhopeclinic.com

### Letter of Interest

I am/ We are interested in becoming benefactors and receiving our care at Our Lady of Hope Clinic.

**Name**

**Birth Date**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

### Contact Information

Primary Contact Person: \_\_\_\_\_

Email address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (Zip)

#### Benefactor Levels

Individual	\$1,200 (if <35 subtract \$300 or >60 add \$300)
Couple	\$2,300 (if <35 subtract \$300 or >60 add \$300 for each)
Kids <19 and Students <23	\$500 (Kids are free after three!)
Clergy	\$500

**Please return this completed form with your full payment. To pay monthly with an automatic withdrawal, please fill out the back of this form (page 2).**

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

**For questions, please contact Julie Jensen at 608-957-1137.**

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

Signed \_\_\_\_\_ Date \_\_\_\_\_



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: \_\_\_\_\_