Hospice of Dubuque

Community. Compassion. Nonprofit.

1670 JFK Road, Dubuque, IA
563.582.1220 · hospiceofdubuque.org

Recurring Donation Form

Your gift enables Hospice of Dubuque to continue its mission of
providing compassionate care for the terminally ill and their loved ones.

CONTACT INFORMATION

Name(s) _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Email _____ ☐ **Yes** ☐ **No**

May we contact you via email?

GIFT INFORMATION

☐ **In Honor of (living)** _____

☐ **In Memory of (deceased)** _____

☐ **I would like the person(s) below notified regarding this gift.** ***Gift amounts are always confidential.***

Name(s) _____

Address _____

City _____ **State** _____ **Zip** _____

PAYMENT INFORMATION

Your gift is tax deductible by law.

$_____ **Donation Amount** ☐ **Weekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Annually**

☐ **Automatic Payment Withdrawal from Checking or Savings Account** ***(form enclosed)***

☐ **Pay by Credit Card** ***(Monthly credit card donations can also be securely made at www.hospiceofdubuque.org)***

Card # _____ **Exp Date** _____ **CVV Code** _____

Signature _____

☐ **Increase my donation to cover the 2.9% credit card service fee**

☐ **Save-a-Stamp Option: Send one tax acknowledgement at the end of the calendar year.**

Please mail completed form(s) to Hospice of Dubuque, 1670 JFK Road, Dubuque, IA 52002.
Please contact us at 563.582.1220 or email cr@hospiceofdubuque.org with questions.

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Authorization for Automated Payment (ACH Debits)

*I (we) hereby authorize **Hospice of Dubuque** to initiate debit entries and to initiate, if necessary, credit and adjustments for any debit entries in error to my/our checking or savings account indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit and/or debit the same account.*

BANKING INFORMATION

Depository (Bank) Name _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Transit/ABA # _____ **Account #** _____
(9-digit #)

GIFT INFORMATION **PLEASE ATTACH A VOIDED CHECK**

Your gift is tax deductible by law.

$_____ **Donation Amount**

Frequency ☐ **Weekly** ☐ **Monthly** ☐ **Quarterly** ☐ **Annually**

Date of Withdrawal ☐ **1st of the month** ☐ **Last Day of the Month**

RELEASE

*This authority is to remain in full force until **Hospice of Dubuque** has received written notification from me (or either of us) of its termination in such time and in such manner as to afford **Hospice of Dubuque** a responsible opportunity to act on it.*

Name(s) _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

_____ _____
Signature *Signature*

_____ _____
Date *Date*

Hospice of Dubuque is a 501(c)(3) nonprofit organization and ensures compassionate care to those with terminal illnesses and their families regardless of income, insurance coverage or ability to pay. All donations are tax deductible.

FOR INTERNAL USE ONLY

Date Received _____

Processed by _____

Termination Notice Received _____

Processed by _____