PARTNERS HEALTHCARE | AT HOME

Find your strength.

***Yes,* I want to support the mission of Partners HealthCare at Home to provide high quality home health care services.**

Please provide us with the following information so we may accurately acknowledge your gift.

Donor's Name: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: _____ E-mail: _____

☐ I wish to make this gift anonymously

GIFT INFORMATION

☐ I would like to make a onetime gift of: $_____.

☐ I would like to make a monthly gift of: $_____ for the next

_____12 months _____ 6 months ____ 3 months or _____ other

Unless you request otherwise, your gift will go unrestricted into the Partners HealthCare at Home Annual Fund. Your unrestricted gift will become immediately available to meet our most pressing needs.

If you would like to restrict your gift, please do so here: _____

PAYMENT INFORMATION

☐ Check enclosed, *made payable to Partners HealthCare at Home.*

☐ Charge my credit card: ☐ VISA ☐ Master Card ☐ Am Ex ☐ Discover

Card Number: _____ Expiration Date:_____

Authorized signature: _____

GIFT AS A TRIBUTE

My gift is given in memory of: _____

My gift is given in honor of: _____

Please notify the following individual/family of my tribute:

Name: _____

Mailing Address:_____

City/State/Zip:_____

Double your gift to Partners HealthCare at Home!

Check with your Human Resources Department to see if your company has a matching gifts program. If they do, request a matching gifts form, fill it out and enclose it with your donation.

Mail with payment to: **Partners HealthCare at Home, Development Office, 1575 Cambridge St, Cambridge, MA 02138.** For more information about giving opportunities, contact the Development Office at 617.952.6880.