Become a CareGiver

To sign up, please complete this form, save, print, and return to the Foundation office.

Donor Information

Full Name: _____ **Employee #:** _____

Job Title: _____ **Department:** _____

Office / Work Location (City): _____ **Birthday:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Phone Number:** _____

Gift Information

CareGivers donations are deducted at each payroll period until the donor changes the gift amount or cancels the gift. A minimum of one hour of hourly wage per month and a commitment of four months is required to join.

Gift Amount

☐ One hour of my hourly wage per month (minimum)

Example: You make $10 per hour, multiply $10 by 12 months ($120) and divide by 26 pay periods = $4.62 per pay period

☐ Other gift amount of $ _____ per month.

Gift Allocation

Please choose the fund where you would like to allocate your gift. 75% of your donation will go to this fund, with the remaining 25% will go to Area of Greatest Need.

☐ Area of Greatest Need
☐ Patient Assistance
☐ Cancer Detection &Treatment
☐ Physician Residency Program
☐ Mental Health
☐ Ribbons of Hope
☐ Nursing Scholarships
☐ Women & Children

Recognition

☐ I prefer that my gift remain anonymous.

Signature

I authorize biweekly payroll deductions to begin the next pay cycle, and agree to a minimum four-month commitment.

The amount of the deduction is confidential, and all gifts are tax deductible.

Signature: _____ **Date:** _____

Name of employee who referred you to CareGivers (if applicable): _____

Return completed form to White River Health Foundation

Office Address: 1989 Harrison Street, Batesville, AR 72501
Mailing Address: PO Box 2197, Batesville, AR 72501 *Phone:*
(870) 262-1834 *Fax:* (870) 262-3248
Email: mreyes@whiteriverhealth.org