



***I want to support Home Health United's mission of keeping people as healthy, safe and independent as possible with my gift***

In the amount of:    \_\_\_ \$25    \_\_\_ \$50    \_\_\_ \$100    \_\_\_ \$250    \_\_\_ \$500    \_\_\_ \$1000    \_\_\_ Other

To be used for:

- |   |   |
|---|---|
| <input type="checkbox"/> Area of greatest need                          | <input type="checkbox"/> Meals on Wheels            |
| <input type="checkbox"/> Foundation endowment fund for future needs     | <input type="checkbox"/> Homemaker / Companion Care |
| <input type="checkbox"/> Hospice  | <input type="checkbox"/> Home Medical Equipment     |
| <input type="checkbox"/> St. Clare Hospice House Resident Fund          | <input type="checkbox"/> Community Education        |
| <input type="checkbox"/> St. Clare Hospice House                        | <input type="checkbox"/> Immunizations              |
| <input type="checkbox"/> Home health services (nursing, therapies, etc) | <input type="checkbox"/> Other _____                |

Name(s) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Your name will be acknowledged as above or  
\_\_\_ check here if you wish your donation to be listed as anonymous.

Payment Options    \_\_\_ Check enclosed    \_\_\_ Bill    Visa/Mastercard (*circle one*)

\_\_\_\_\_ *Card #*

\_\_\_\_\_ *Exp. Date*

\_\_\_\_\_ *Signature*

*Optional:* \_\_\_ In Memory of    \_\_\_ In Living Tribute to    \_\_\_ In honor of my *Guardian Angel* caregiver

Name \_\_\_\_\_

If you would like us to send an acknowledgement of your gift, please indicate below:

Name \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Mail completed form to:**  
Home Health United-Visiting Nurse Service Foundation  
4639 Hammersley Rd, Madison, WI 53711  
Or call (608) 276-7590 for further information  
*Thank you for visiting [www.HomeHealthUnited.org](http://www.HomeHealthUnited.org)*