



Health Care for All- Minnesota DONATION FORM

Name _____ Email _____
Address _____ City _____
State/Zip _____ Home Phone _____
Work Phone _____ Cell Phone _____
Occupation _____ Senate District/ House District _____

You can use my name as an endorser of single-payer

Here is my contribution to HCAMn:

\$50 \$75 \$100 \$150 \$200 \$500 \$1000 Other: _____

I wish to make this contribution:

One Time Annually Quarterly Monthly

I want my contribution to remain anonymous

Payment Method:

- Check enclosed payable to "HCAMn" or "Health Care for All- Minnesota"
 Electronic Funds Transfer (ACH)-from checking or savings account (additional form needed)
 Credit Card: Visa MasterCard Discover American Express

Card Number: _____ Expiration: _____ / _____

Name on Card: _____

Billing address: _____
if different than above

Signature: _____ Date: _____

I'd like to Volunteer!

- | | |
|--|--|
| <input type="checkbox"/> General Volunteer | <input type="checkbox"/> Host a house party |
| <input type="checkbox"/> Contact Legislators | <input type="checkbox"/> Mailings |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Phoning |
| <input type="checkbox"/> Fundraising | <input type="checkbox"/> Write Letters to Editor/ Blog Entries |
| <input type="checkbox"/> Event Help and Planning | <input type="checkbox"/> Other: _____ |

HCAMn is a registered 501(c)4 non-profit. Contributions support advocacy & lobbying & are not tax deductible.

Donations can also be made via credit card or electronic funds transfer at www.hcamn.org/donate

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