



## Maple Society Monthly Giving Enrollment

The Maple tree is a traditional symbol for the virtues of **offering and generosity**. Thank you for your interest in Alive's monthly giving program! Your monthly gift will help to guarantee the support of programs at Alive all year long.

### Programs such as:

- Hospice care for uninsured and underinsured patients
- Hospice care for pediatric hospice patients
- Grief support for adults and children
- Children's and teens' grief support camps
- Music therapy

### Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Credit Card Authorization Form

Withdraw my contribution on:  1st of the month *or*  15th of the month

Credit card type:  Visa  MasterCard  Discover  American Express

Credit card number: \_\_\_\_\_

CVV number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Monthly donation amount: \$ \_\_\_\_\_

*Note: You may cancel your monthly contributions at any time.*

I would like to make my gift by:

Credit card  
*Please fill out the credit card authorization form on this page.*

Bank draft  
*Please fill out the bank draft authorization form on the second page.*

I would like to make this donation  
\_\_\_ in memory of \_\_\_ in honor of:

Additional Comments:



### Please mail this form to us at:

Alive Hospice  
Attention: Katy Dorais  
1718 Patterson Street, Nashville, TN 37203



**Authorization Agreement for Automatic Bank Draft**

I hereby authorize **Alive**, hereinafter called ORGANIZATION, to initiate debit or credit entries to my  Checking Account /  Savings Account (*select one*) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit/credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Financial Institution Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

This authorization is to remain in full force and effect until ORGANIZATION has received written notification from me of its termination in such time and in such manner as to afford ORGANIZATION and DEPOSITORY a reasonable opportunity to act on it.

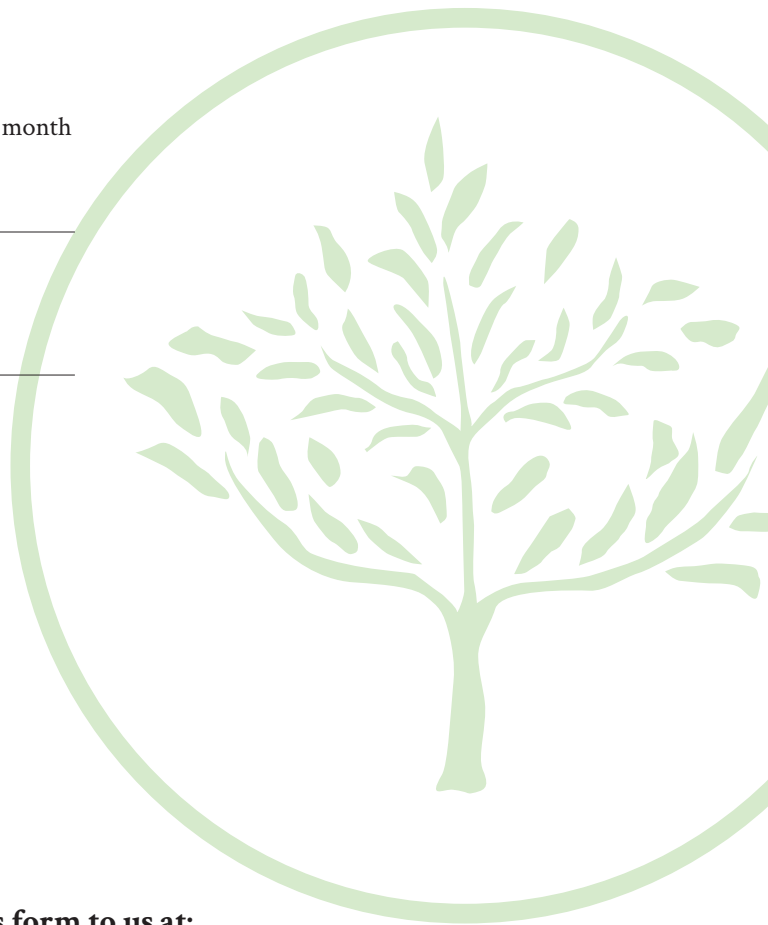
Amount to withdraw monthly: \$ \_\_\_\_\_

Withdraw my contribution on:  1st of the month or  15th of the month

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: Please provide a voided check with this authorization form.**



**Please mail this form to us at:**

*Alive Hospice  
Attention: Katy Dorais  
1718 Patterson Street, Nashville, TN 37203*