



2021 Workplace Giving Donation Form

MercyGives.org

Step 1: Employee Information

Name: _____ Phone: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Colleague ID#: _____ Department: _____
Work email: _____ Home email: _____

Step 2: Designation (select one)

- ☐ Area of Greatest Need
☐ Healthcare for the Homeless
☐ Colleague Crisis Fund
☐ Medical Technology & Innovation
☐ Other: _____

Step 3: Contribution (choose one of the options below)

A. Payroll Deduction

Per paycheck (every two weeks):

☐ I understand deductions will rollover year to year unless I notify the Office of Philanthropy at 413.748.9920.

☐ \$20 ☐ \$10 ☐ \$4 ☐ \$2 ☐ Other: _____

Onetime Deduction:

☐ \$500 ☐ \$250 ☐ \$100 ☐ \$50 ☐ Other: _____

B. Check or Cash

I would like to donate \$ _____ by ☐ Check ☐ Cash
(Checks should be made payable to Mercy Medical Center. Please DO NOT mail cash.)

C. Change my current deduction per paycheck (every two weeks):

As of this date: _____ to \$ _____

D. Credit Card (Please include ALL information)

I would like to donate \$ _____ per ☐ Month ☐ Quarter ☐ Twice a Year ☐ One Time Charge

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card #: _____ Expiration Date: _____ CVV Code: _____

Billing Address: _____ City: _____ State: _____ Zip Code: _____

Name as it appears on card: _____

Step 4: Appreciation Gift:

Gifts of \$100 or more receive a "Be Inspired" long-sleeve men's ____ or ladies ____ t-shirt.

☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2X ☐ 3X ☐ No gift thank you

Step 5: Submit—Office of Philanthropy – funddevelopment@trinityhealthofne.org

Signature Required: _____ Date: _____

☐ I am interested in including the hospital in my will or life insurance. Please contact me.

☐ I wish to remain anonymous on any publication of donors.