



AFRICAN AMERICAN FAMILY SERVICES

## Contribution Form

### Donor Information (Please print or type)

Name	
Billing address	
City	
State	
Zip Code	
Telephone (home)	
Telephone (business)	
Email	

### Contribution Information

I (We) pledge a total of \$ \_\_\_\_\_ to be paid: \_\_\_\_ now \_\_\_\_ yearly.

I (We) plan to make this contribution in the form of: \_\_\_\_ cash \_\_\_\_ check \_\_\_\_ credit card.

Credit Card type (VISA/MC)	
Credit Card number	
Expiration Date	
Authorized signature	

### Acknowledgement Information

Please use the following name(s) in all acknowledgements:

\_\_\_ I (We) wish to have my (our) gift remain anonymous.

\_\_\_ I (We) wish to give this gift in honor or memory of \_\_\_\_\_.

### Designation Information

Please designate my (our) gift to one of the following agency divisions:

\_\_\_ Chemical Health

\_\_\_ Mental Health

\_\_\_ Family Services

\_\_\_ Agency Operations

Please make checks or other gifts payable to:

**African American Family Services**

PO Box 8900

Minneapolis, MN 55408-0900