Together we shine.

2024 Annual Campaign

CHI Health
Plainview Foundation

Employee Information

* Full Name: ______________________________ * Employee ID: ______________

* Work Location: ______________________ * Department: ______________________

* Work Email: ______________________ Mobile Phone: ______________________

* Home Address: ______________________ * City: ______________ State: _____ Zip: _________

❑ I would like my gift to remain anonymous.

* *denotes a required field*

Payroll Donation Options...

NOTE: New HR rules require that all PTO Vacation donations be a minimum of one (1) hour per pay period per fund. You will be able to donate a minimum of one (1) hour per fund every other pay period if you wish.

Specific Amount (for eligible employees)

Please deduct the amount entered (per pay period, or one-time, as noted below).

❍ Every pay period *Donation Amount:* $ ______________________

Start my recurring donation: ☐ Next pay period ☐ January 10, 2025

❍ One-time Only *Donation Amount:* $ ______________________

Take my one-time donation: ☐ Next pay period ☐ January 10, 2025

PTO Vacation Hours (for eligible employees)

Please deduct the number of PTO Vacation hours entered (per pay period or one-time as noted below).

❍ Every pay period *Number of hours per pay period:* ☐

Start my recurring donation: ☐ Next pay period ☐ January 10, 2025

❍ Every other pay period *Number of hours every other pay period:* ☐

Start my recurring donation: ☐ Next pay period ☐ January 10, 2025

❍ One time only *Number of hours one time only:* ☐

Take my one time donation: ☐ Next pay period ☐ January 10, 2025

The gross value of donated PTO hours will be forwarded to the fund designated; you will pay taxes on the gift (gift is fully tax deductible) and it will be listed on your pay stub each pay period.

My signature indicates I understand that the information on this form will be entered in the Foundation database and used to administer this donation.

If payroll deduction is chosen: I authorize CHI Health Plainview Foundation to withhold my deduction as indicated above. Payroll deductions will continue until I notify the Foundation to stop. (*An email will be sent to you each year detailing any current continuing commitments you have on record.)*

* Signature: ______________________ * Date: _________

I would like my gift to support...

Plainview

❑ Hospital and Staff Support: *Funds will be used to enhance patient care, enrich staff well-being, support program needs, and purchase or upgrade equipment and other items for the hospital and its patients.*

Additional Information

ONLINE GIVING

Payroll deduction (one time or per pay period), credit/debit card (one time or monthly) visit:

Give.chihealth.com/PlainviewAnnual

PAYROLL DEDUCTION INFORMATION

- Deduction must be a minimum of **$5 per pay period**.
- If multiple funds are chosen, deduction must be a minimum of **$5 per pay period per fund**.
- Total donation will be divided equally between all funds.

CASH OR CHECK

Amount $______________________

Please return this completed form, along with your gift, to your local foundation.

Thank you for your support! Please return forms to:

CHI Health Plainview Foundation
704 N 3rd St, Plainview, NE 68769-2047
Questions? Contact Diane Blair
(402) 582-4245 x1330 or Diane.Blair@chihealth.com

Scan this code to make your donation online!

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