Donate Now

Thank you for considering a gift through the Partners in Health Giving Society to help support important initiatives aimed at improving health and quality of life for patients and families at Aspirus and people in our community.

Print this form and fill it out. You can then mail it to:

Aspirus Health Foundation
425 Pine Ridge Boulevard
Wausau, WI 54401

CHOOSE YOUR GIFT

Choose your gift level from the following options:

Excellence: $10,000 +
Life: $5,000 - $9,999
Health: $2,500 - $4,999
Hope: $1,000 - $2,499
Integrity: $500 - $999
Strength: $250 - $499
Courage: $100 - $249
Compassion: Gifts up to $99

Enter your gift amount:

If a matching gift from your company or business is applicable, please send the appropriate company form(s) to: Aspirus Health Foundation, 425 Pine Ridge Blvd., Wausau, WI 54401.

Please choose an area that you care about, and contribute in a way that is right for you. If you'd like to talk about your options, please call the Foundation at **715.847.2470** or email us at **ahf@aspirus.org**. Please know that 100% of your gift will directly support the cause or area you choose to support, and every gift at every gift level will make a difference.

I would like to make my Partners in Health gift to the area I care about as follows:

Greatest Needs & Community Health
Birthing Center
Compassion Clothing Closet
Cancer Center
Family House
Heart Care
Hospice Care
NICU
Palliative Care
Rainbow's End Camp for children with special needs
Reach Out & Read Program
Breast Health
Other

I would like my gift treated as anonymous.

Is your gift in memory or in honor of someone? Yes No

GIFT INFORMATION

If you chose yes above, please fill out the applicable fields below:

My gift is made in memory of:

My gift is made in honor of:

Please send notification of my gift to:

First Name:

Last Name:

Relationship to memorial/tribute:

Address:

City: **State:**

Zip/Postal Code:

Email:

DONOR INFORMATION

First Name:

Last Name:

Address Line 1:

Address Line 2

City: **State:**

Zip/Postal Code:

Email Address:

Phone:

PAYMENT INFORMATION

Cardholder's Name:

Credit Card Type: Visa Mastercard Discover

Credit Card Number:

Credit Card Expiration: **Month:** **Year:**

Card Validation Code:

BILLING INFORMATION

Check if same as donor:

Address Line 1:

Address Line 2:

City: **State:**

Zip Code:

Phone #:

Please remove my name from the Aspirus Health Foundation mailing list.

Additional Comments: