



**Request For Automatic ACH/Bank Draft Payment**

I (we) authorize Hospice of Wichita Falls to initiate entries to debit my (our) account described below:

Checking Account No. or Savings Account No. \_\_\_\_\_

Financial Institution's Routing Number \_\_\_\_\_

Financial Institution's Name \_\_\_\_\_

Financial Institution's Address \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***Payment Frequency:***

I/We wish to make monthly gift payments of \$ \_\_\_\_\_ on the  
 1<sup>st</sup> of every month    or     day 15 of every month    (check one)

Posting to my/our account for a period of (check one):  
 6 months     12 months     24 months     until I request that you stop

***ATTACH A VOIDED CHECK OR SAVINGS SLIP TO THIS AUTHORIZATION.***

This authority is to remain in full force and effect until Hospice of Wichita Falls has received written notification from me (or either one of us) of its modification or termination in such time and manner as to afford Hospice of Wichita Falls a reasonable opportunity to act on it.

Signature \_\_\_\_\_

Full Name (*print*) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Special Instructions: (is donation in memory/honor of someone special, etc.)  
\_\_\_\_\_

**Return Completed Form to:**  
Hospice of Wichita Falls  
4909 Johnson Road  
Wichita Falls, TX 76310  
940-691-0982

***Thank you for your gift***