

# ICARE Donations

I would like to help ICARE provide quality services through my contribution.

(Please Print or Type)

Name:	
City:	
Address:	
State:	
Zip:	

I am enclosing my check for \$ \_\_\_\_\_

Or

I would like to charge my donation to my credit card.

Card Type: \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard

Name as it appears on the card:

\_\_\_\_\_

Card Number:

\_\_\_\_\_

Card Expiration date: \_\_\_\_\_

I authorize ICARE to deduct \$ \_\_\_\_\_ from my credit card by signing below.

Card holder's Signature: \_\_\_\_\_

\*ICARE respects the privacy and confidentiality of its patrons, clients, and contributors and therefore will not share information with any other agency or organization.

Please send this form and enclose your check (if paying by check) to:

**ICARE**  
**321 East First St.**  
**Iowa City, IA 52240**