Electronic **F**unds **T**ransfer Authorization Form

☐ ***Yes, I wish to enroll in Esperanza's EFT program.***

- Please accept my gift of $________ to be given monthly via electronic funds transfer (EFT).
- Please begin my electronic fund transfers the month of: _________________________
- Please transfer my contributions on or about (please check one):

☐ the 5th of the month ☐ the 20th of the month

I hereby authorize Esperanza Health Center to electronically transfer the total amount indicated above on a monthly basis from my bank account. This agreement will remain in effect until I notify Esperanza Health Center in writing (via mail or email) that I wish to increase, decrease or discontinue my monthly contribution, which I may do at any time.

____
Name

____
Address

____
City ST Zip

____ (____) ________________
E-mail Address Phone

____ ____________________
Signature Today's Date

Please mail this signed/dated form with your first contribution check in the amount of your monthly EFT gift to the address below. We will set up your EFT contribution with your bank account information.

Questions? Please contact us at 215-807-8614 or at development@esperanzahealth.com.

Thank you!

Please mail this completed form with your first contribution check to :
Esperanza Health Center
Attn: Development
4417 N. 6th Street
Philadelphia, PA 19140-2319

Phone: 215-807-8614
Fax: 215-807-8951
E-mail: development@esperanzahealth.com
Web: www.esperanzahealth.com