PAYROLL DEDUCTION AUTHORIZATION FORM

DATE_____

EMPLOYEE NAME _____

PERSONNEL NUMBER OR LAST FOUR DIGITS OF SSN _____

FACILITY NAME/NUMBER_____

Choose ONE method of contribution**:**

- ○ **I wish to contribute $_____ per pay period.** (This contribution will continue indefinitely and is the most beneficial to The HOPE Fund)
- ○ I wish to contribute $_____per pay period for _____ pay periods (please indicate the number of pay periods you would like this deduction to be made to the HOPE Fund).
- ○ I wish to make a one-time contribution of $_____ to the HOPE Fund via payroll deduction.
- ○ I wish to increase my current contribution by $_____ to a new total of $_____ per pay period to the HOPE Fund via payroll deduction.

◉ My name acts as authorization to Kindred Healthcare to initiate payroll deductions for the HOPE Fund as stipulated above.

EMPLOYEE NAME_____

DATE _____

Submit Form

REV (09/26/2018)