Kindred Healthcare

Matching Gift Request
Company Officers

Contributor Section		
Contributor: Please type or print the information in this section.		
Contributor		
Name:	Street Address:	
City:	State:	Zip:
Recipient		
Non-Profit Organization Name:	Street Address:	
City:	State:	Zip:
Gift		
Gift: ☐ Securities (Provide complete description.) ☐ Cash/Check		Amount:
I certify that neither my family nor I will derive any direct or indirect financial or material benefit from this contribution. I authorize the above-named recipient organization to report this gift to Kindred Healthcare for the purpose of applying for a matching gift. I certify that my gift is a voluntary contribution, that it fully complies with the provisions of the program, and does not represent in any way a fee for a service or benefit.		
Title:	Signature:	Date:
Contributor: Send this form along with the gift to the recipient.		

Recipient Section		
Recipient: Please certify receipt of the gift from the Contributor by completing the following section. If this is your first matching gift request to Kindred Healthcare, enclose a copy of your Internal Revenue Service 501(c)(3) determination letter and a brief description of your institution's primary purpose.		
Recipient		
Organization Name:	Street Address:	
City:	State:	Zip:
Telephone Number:	Fax Number:	
Gift		
Amount:	Date Received:	
I hereby certify that this organization meets the eligibility requirements of Kindred Healthcare and that neither the donor nor Kindred Healthcare will derive any personal material benefit from this gift or match.		
Authorized Officer's Name:		
Title:	Signature:	Date:
Recipient: Send this completed form and any required enclosures to: Kindred Healthcare, Inc. Attn: Vice President, Communications 680 South Fourth Street Louisville, KY 40202		

Kindred Use Only		
Approved By:	Date:	Account #: