



alameda county health care foundation

1411 East 31st Street v Oakland, California 94602 v (510) 535-7424 v Fax (510) 532-0168

Donor Advisory Funds DEFINITION OF SERVICES

Program Name _____

Contact Information

Authorized contact _____ QIC CODE _____

Department _____

Address _____

City, state, zip _____

Email address _____

Phone number _____ Fax number _____

Date Completed _____

Program Description

Must state the purpose of the Program / Project and be signed by the person authorized to request deposit and disbursement of funds (use separate sheet for additional information, if needed):

Total Budget \$ _____

Time Period From: _____ To: _____

