Clear Form

New Jersey Health
Charitable Gift Fund
A New Jersey Health Affiliate

Donor-Advised Fund – Donor Application

- Please type or print clearly in ALL CAPITAL LETTERS
- If you prefer to complete your application on-line, please visit www.njhealthcharitable.org
- If you need assistance, please call us at (908) 315-5870

1. Donor-Advised Fund Information

Choose a name for your donor-advised fund. You may name it for yourself, your family, in memory of someone, or for a particular charitable purpose. Unless you request anonymity when you recommend grants, the name below will appear on our correspondence with organizations that receive grants from your donor-advised accounts.

_____
Donor-Advised Fund Name

May we list your fund name in our Annual Report? ◯ Yes ◯ No

2. Primary Advisor

Identify the Primary Advisor for the fund (typically, this is also the Primary Donor to the fund)

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

_____ _____
City/State Zip code

_____ _____
Email Primary Telephone #

3. Joint Advisor

You may name an individual (such as a spouse, family member, friend or other) as Joint Advisor to your fund who also has the authority to recommend grants, view fund information and name successors. They will assume the role of Primary Advisor to the account in the event of the death of the Primary Advisor.

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

City/State Zip code

Email Primary Telephone #

4. Secondary Advisor(s)

You may name Secondary Advisors to your fund who will have the authority to recommend grants. Secondary Advisors will not succeed the Primary and Joint Advisors. To indicate additional Secondary Advisors, please attach a separate sheet.

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

First Name, MI, Last Name Date of Birth

Street Address

City/State Zip code

Email Primary Telephone #

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

First Name, MI, Last Name Date of Birth

Street Address

City/State Zip code

Email Primary Telephone #

5. Succession Plan

You may name individuals as Successor Advisors to succeed you in advising on the fund after the death of the Primary and Joint Advisors **OR** you may elect to name specific charities as the Charitable Beneficiaries of the funds. These recommendations may be changed at any time. To indicate additional Successor Advisors or Charitable Beneficiaries, please attach a separate sheet.

In the event that the Charitable Beneficiary no longer exists, New Jersey Health Foundation, Inc.'s Board of Directors will award grants to a charity whose mission is similar to the original charity.

A. Successor Advisors – Individual(s)

◯ **Option 1**: Retain assets in fund; Successors will share fund administration; **OR**

◯ **Option 2:** Create new separate funds, and divide assets equally among Successors.

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

_____ _____
City/State Zip code

_____ _____
Email Primary Telephone #

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

_____ _____
City/State Zip code

_____ _____
Email Primary Telephone #

Charitable Beneficiaries – Charity(ies)

○ **Option 1**: Distribute all of the remaining assets in the fund to the following charity(ies); **OR**

○ **Option 2:** Designate a specific percentage to be annually distributed to the charity(ies).

_____ _____
Charity Name Annual % (Option 2 only)

_____
Street Address

_____ _____
City/State Zip code

_____ _____ _____
Contact Name Employer ID # (if known) Primary Telephone #

_____ _____
Charity Name Annual % (Option 2 only)

_____
Street Address

_____ _____
City/State Zip code

_____ _____ _____
Contact Name Employer ID # (if known) Primary Telephone #

6. Anticipated Timing of Grant Payouts:

○ Less than two years from date of original Fund Agreement.
Funds will be included in the Money Market Pool.

○ Two years or more from date of original Fund Agreement.
Funds will be invested in the Investment Pool.

7. **Irrevocable Contribution** ($10,000 MINIMUM INITIAL DONATION)

Please complete the information below. If your employer matches charitable contributions to charities with donor-advised fund programs, please include the appropriate company paperwork.

A. Donor Information

Identify all registered owners of non-cash assets being donated. Note: NJHCGF's gift acknowledgement, which is provided for federal tax substantiation purposes, will be sent to the person(s) or trust listed below.

Primary Donor ◯Mr. ◯Mrs. ◯Ms. ◯Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

_____ _____
City/State Zip code

_____ _____
Email Primary Telephone #

Joint Owner ◯Mr. ◯Mrs. ◯Ms. ◯Dr.

_____ _____
First Name, MI, Last Name Date of Birth

_____
Street Address

_____ _____
City/State Zip code

_____ _____
Email Primary Telephone #

Trust (A copy of the Trust Agreement with any amendments must accompany all initial contributions from trusts.)

_____
Name of Trust Agreement

_____ _____
Taxpayer Identification Number Trust Date

_____ _____
Trustee (First Name, MI, Last Name) Primary Telephone #

B. Assets to be Contributed

◯ **Cash**

$_____ ◯ By Check ◯ By Wire (See instructions in Section C)
Dollar Amount

◯ **Stock and Bonds**

See instructions in Section C.

◯ **Mutual Funds**

Please contact us at (908) 315-5870.

◯ **Grant or Transfer from Private Foundation or Donor-Advised Fund**

$_____ ◯ By Check ◯ By Wire (See instructions in Section C)
Estimated Dollar Amount

◯ **Credit Card**

◯ Visa ◯ American Express ◯ Mastercard ◯ Discover

Gift amount $ _____

Account Number _____ Security Code _____ Expiration Date _____

Name on card _____

Signature _____

Cardholder Address _____

City _____ State _____ Zip _____

C. Transfer Instructions

Check	Wire	Stock and Bonds	Mutual Funds
Make payable to: New Jersey Health Charitable Gift Fund **Mail to:** 120 Albany Street Tower II, Suite 850 New Brunswick, NJ 08901 **Tax ID#:** 03-0430873	**Bank:** Amboy National Bank **ABA #:** 021204416 **A/C Title:** New Jersey Health Foundation **A/C Number:** 171271	DTC #0954/Mellon Agent Bank #26017, Inst. ID#93752 For: NJ Health Foundation / Acct#NJHF1005002 Attn: Stephen Kirsch	Please contact us at (908) 315-5870 or charitablegiftfund@njhf.org

8. **Acknowledgement of Terms** (This section must be signed by the Primary and Joint Advisor, if one is listed, as well as all donors or trustees as named in Section 7.)

I understand that (i) my gifts of property are irrevocable and unconditional contributions when received and accepted by New Jersey Health Charitable Gift Fund (NJHCGF); (ii) I relinquish all ownership and control over the donated funds or property to NJHCGF, (iii) NJHCGF retains exclusive control over contributed assets and (iv) NJHCGF is free to accept or reject any grant recommendations made by me or any of my advisors regarding donated funds or property. I acknowledge that I have read the NJHCGF Policies and Guidelines and agree to the terms and/or conditions contained therein. I certify that, to the best of my knowledge, all information included in this application is accurate and I will notify NJHCGF in writing of any changes.

_____ _____
Primary Advisor Date

_____ _____
Joint Advisor (if any) Date

_____ _____
Primary Donor (if different than Primary Advisor) Date

_____ _____
Joint Owner (if any) Date

_____ _____
Trustee (if any) Date

9. **Return this completed form with your payment by mail to:**

New Jersey Health Charitable Gift Fund
120 Albany Street, Tower II, Suite 850 / New Brunswick, NJ 08901