

DONATION FORM

Thank you for supporting Care Resource!
Your contribution makes a direct impact in our ability to continually expand our services and provide quality healthcare for all who need it.

Donation Amount

Select the amount of your donation below:

\$25

\$50

\$100

\$500

Other

(Specify Amount:

\$ _____)

MIAMI-DADE COUNTY

Midtown

3801 Biscayne Blvd.
Miami, FL 33137
T: 305.576.1234
F: 305.571.2020

Little Havana

1901 S.W. 1st Street
3rd Fl.
Miami, FL 33135
T: 305.203.5230
F: 305.203.5231

Miami Beach

1680 Michigan Avenue
Suite 912
Miami Beach, FL 33139
T: 305.534.0503
T: 305.673.3555
F: 305.538.4090

BROWARD COUNTY

Fort-Lauderdale

871 West Oakland Park Blvd.
Ft Lauderdale, FL 33311
T: 954.567.7141
F: 954.565.5624

Oakland Park

3160 Powerline Road
Oakland Park, FL 33309

www.CareResource.org

@CareResourceFL

/CareResource

#CareResource

Designation

Specify where you would like your donation to go

Where it is needed most

Capital Fund

Emergency Assistance Fund

Food for Life Network Food Pantry

Other (Specify Designation: _____)

Tribute Gift

This gift is in honor, memory, or support of someone.

In honor of

In memory of

Person's name (_____)

Please notify the following person of my gift

Specify name and address or email:

(_____)

Billing Address

Name: _____ Email: _____

Phone: _____ Country: _____

Address: _____

City: _____ Zip: _____

State: _____

Payment Details

Cardholder name: _____

Cardholder number: _____

Expiration date: _____ Card security code: _____

Cardholder signature: _____

Company Matching Gifts

This gift can be matched Matching Company Name: _____

Please fill this form and send it with your donation to:

Care Resource Community Health Centers

c/o Development

3510 Biscayne Blvd, Miami, FL 33137