



Compassionate Health Supporters



We are so grateful that you are considering becoming a monthly donor to Community Health Center. In becoming a Compassionate Health Supporter of CHC, your monthly gift will help us achieve our mission throughout the year. We appreciate your consideration, and can contact the Advancement Office at (508) 477-5990 at any time to adjust, pause or end your monthly giving.

Name: _____

Address: _____

Town: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Credit Card Number (Visa, MC, AmEx, Discover): _____

Expiration Date: _____ CVV: _____

Monthly Giving Information

I/We wish to make payments of \$_____ on the 1st, 15th or 30th (circle one) of each month.

With payments to begin on _____

___ Please send me one acknowledgment letter for tax-purposes at the close of the calendar year.

___ This gift is eligible for matching funds from: _____

___ Please keep my/our gift anonymous.

Signature: _____ Date: _____

Please return form to:

Community Health Center Office of Advancement
107 Commercial Street
Mashpee, MA 02649

If you have any questions, please contact cellis@chcofcapecod.org or (508) 477-5990.

Thank you for your support to help CHC achieve our mission!

To donate online, please visit CHCofCapeCod.org/donation