margaret anna
cusack care center

Long-term skilled nursing care
At the historic St. Joseph's Home for the Blind

PRINT OUT & MAIL IN DONATION FORM

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone (day):_____ Phone (evening):_____

Email: _____

WAYS TO GIVE

Please check off one of the following:

☐ I am making a general contribution to be used in any of your programs.

☐ I want to make a memorial gift in memory of: _____.
Please include an acknowledgement to: Name: _____
Address: _____
City, State, Zip: _____

☐ My company has a Matching Gift program. The matching gift form is enclosed.

☐ I intend to include the Margaret Anna Cusack Care Center in my will.

FINANCIAL INFORMATION

☐ Enclosed, is my check made payable to the Cusack Care Center in the amount of:

__$50 __$100 __$250 __$500 __$1000 __other_____

☐ Please charge my contribution in the amount of $_____to my:

__Visa __MasterCard __AMEX __Discover

Credit Card #_____ Exp. _____

Signature_____

Name (as it appears on card):_____

Thank You!
Please include this form and the check for the total amount of your tax-deductible donation in an envelope and mail to the address below.

537 Pavonia Avenue Jersey City, NJ 07306 * 201.653.8300 * Fax 201.653.7705 * www.cusackcarecenter.org