



Caring Partners Program

Enrollment Form

Please specify how you would like your gift (name) listed on the
Caring Partners wall: _____

Your Annual Caring Partners gift: \$ _____

Your Caring Partners gift payment: \$ _____

*Please specify payment deduction frequency below

Deduction Frequency:

monthly quarterly semi-annual annual

Please specify gift payment method:

Credit Card Deduction MC Visa AE
_____ Expiration: _____

Enclosed cancelled check for debit from checking account
(Processed securely through Caring Habits Inc.)

Check will be received by December 31st.

Name: _____

Address: _____

Telephone: _____ Email: _____

Your signature: _____

Print Name: _____

Please complete this form and mail or fax to the Ronald McDonald House.
635 West Lexington St., Baltimore MD 21201 Fax: 410.727.6177

Questions regarding your Caring Partners Gift can be directed
to Debbie Hood at 410.528.1010 or debbie@rmhbaltimore.com.

Thank You!