



## Donate to Community Health Programs!

Thank you for helping to improve the health and well-being of the people of our community.

Your donation goes a long way at CHP!

- \$30 provides a hungry family with an emergency food basket that feeds a family of four for three days.
- \$50 provides a new car seat for the Car Seat Rental Program at the CHP Family Network.
- \$100 provides health education services to adult men with cardiovascular risks.
- \$300 provides a child (birth through three years old) a complete Early Intervention assessment and evaluation from CHP First Steps.
- \$500 provides six months of weekly playgroup time for parents and their children.

For every dollar spent on feeding young children and pregnant mothers in the CHP WIC nutrition program, three dollars in future medical costs are saved.

Please complete and return the enclosed Donation Form with your donation.

**We appreciate your support.**

## Community Health Programs Donation Form

### YOUR INFORMATION (\* Indicates a required field.)

Title: \_\_\_\_\_  
First Name: \* \_\_\_\_\_ Last Name: \* \_\_\_\_\_  
Address Line: \* \_\_\_\_\_  
Address Line 2: \_\_\_\_\_  
City: \* \_\_\_\_\_ State: \* \_\_\_\_\_ Zip: \* \_\_\_\_\_ Country: \* \_\_\_\_\_  
  
Daytime Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

Please provide your name as you would like to be acknowledged if different from above.

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### BILLING INFORMATION

Check this box if your billing information is the same as the information above. If different, please complete the following fields:

Billing Address Line 1: \* \_\_\_\_\_  
Billing Address Line 2: \_\_\_\_\_  
City: \* \_\_\_\_\_ State: \* \_\_\_\_\_ Zip: \* \_\_\_\_\_ Country: \* \_\_\_\_\_

### Amount of Donation: \*

\_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$100 \_\_\_ \$250 \_\_\_ \$500 \_\_\_ \$1,000 and above

All contributions are tax deductible to the extent allowed by law.

I would like to make a gift of stock.  
If you would like to make a gift of stock, please check this box and someone from our Development department will contact you.

I am paying by: \_\_\_ Check \_\_\_ Credit Card

### Credit Card Information

\_\_\_ Charge my gift to: \* \_\_\_ MasterCard \_\_\_ Visa \_\_\_ AMEX \_\_\_ Discover

Account #: \* \_\_\_\_\_

Expiration Date: \* \_\_\_\_\_

Signature: \* \_\_\_\_\_

Please complete all of the required fields and mail your completed form and donation to:

Community Health Programs, 54 Castle Street, P.O. Box 30, Great Barrington, MA 01230

**THANK YOU!**