Name: ____

Address: ____

City: ____________________________ State: ____________ Zip: ____________

Phone: ______________________________ E-mail: ________________________

Payment Options:

☐ I have enclosed a check ☐ I would like to charge my contribution

Contribution amount: (please check one)

☐ $25 ☐ $50 ☐ $100 ☐ $500 ☐ Other amount: __________

Credit card ☐ Visa ☐ MasterCard ☐ American Express

Card Number:________________________________ Expiration Date: __________________

Signature: ____

(Please sign above after printing this form)

☐ **My employer has a matching gift program:**

☐ Enclosed is my company's form ☐ I will forward the form

☐ **This gift is in honor of:**

Recipient Name: ____

Recipient Address: ____

City: ____________________________ State: ____________ Zip: ____________

Personal message (optional): ____

____

Please mail your tax-deductible donation with this completed form to:

The Coalition of Behavioral Health Agencies
Atten: Phillip Saperia
90 Broad St, 8th Fl
New York, NY 10009
212.742.1600
212.742.2018 (fax)

Every little bit helps make the difference!