



Please accept my gift of

- \$25
 \$100
 \$500
 \$1,000
 Other _____

To Bridgeport Hospital's

REACH Program

In support of

- Prenatal Care – Psych APRN
- REACH Program for Children, Ages 5-12
 - Child Psychiatrist
 - Free Transportation Program
- REACH Program for Adolescents, Ages 12+
 - Licensed Clinical Social Worker
 - Recreation/Music/Art Therapist
 - Say Teen! Guided Support Group
- Angel Fund
- Helping Hands Fund
- Plant/Capital Needs – Upgrade Physical Facility
 - Landscaping out front
 - Outdoor play area/seating, canopy, landscaping
 - Murals and new equipment – interior
 - Patient Equipment and furniture upgrade

Name _____ Phone _____ Email _____

Address _____ City, State, Zip _____

____ Enclosed is my check in the amount of \$_____ payable to "BHF/REACH"

____ Please charge my credit card in the amount of \$_____

Card # _____ Exp Date _____ CVV _____

Name on card _____

Thank you for your donation!

Mail this form with your check payable to "BHF/REACH" to:

REACH
 Bridgeport Hospital Foundation
 267 Grant Street
 Bridgeport, CT 06610

