Taste of Hope

Sponsorship Form:

Sponsor Information:

Last Name:_____First Name:_____
Email:_____Phone #:_____
Address:_____
City:_____State:_____ Zip:_____

Family of two or more to be sponsored:

Name:_____ Number of members:_____
I would like to support this family by paying;
☐ $660 for the year
☐ $55 a month for a 12 month minimum

Family of 2 or less to be sponsored:

Name:_____ Number of members:_____
I would like to support this family by paying:
☐ $540 for the year
☐ $ 45 a month for a 12 month minimum

Individual to be sponsored:

Name:_____
I would like to support this individual by paying:
☐ $420 for the year
☐ $35 a month for a 12 month minimum

Payment Options:

☐ Send Check to: Taste of Hope @3463 State Street Suite 281, Santa Barbara, CA 93105
☐ ACH monthly payment
Routing #_____Account #_____ (please include a cancelled check)
☐ Credit Card _____Monthly _____ Yearly support
Card Type_____ Card #_____Expiration __/___/___3 digit code _____