Office Use Only	
Date Rcvd. /Paid	
Receipt #	
Cash Money Order Check Data Entry Welcome	

HOPE Network for Single Mothers
Membership Application

Enclose dues of $5 (cash/check/MO) and mail to **HOPE Network, PO Box 531, Menomonee Falls, WI 53052**

Date: _____

PLEASE PRINT:

* **PLEASE NOTIFY US IF YOUR ADDRESS CHANGES**
[Address changes cost your Network hundreds of dollars!]

Name_____

Address _____

City _____, WI Zip _____ Home Phone (_____) _____

Work Phone (_____) _____

Your Year of Birth _____ Cell Phone (_____) _____

Email (print clearly) : _____ (only used by us for announcements or free ticket notifications)

If Pregnant, **Due Date** _____

Your race (*optional*; demographic statistics required for many donors/grants): _____

Your Dependent Child (ren) - *under age 18, living with you:*

NAME **First and Last**	**(B)OY** **OR** **(G)IRL**	**BIRTH DATE**

**Our mission is to help single mothers and their children.
Membership runs from January 1 – December 31.
(You must send in the $5 membership dues yearly to renew your membership.)

Person or agency that referred you_____