

FOOD BANK		Head of Household Information					
First Name*							
Last Name*							
Dat	te of Birth*						
Street Address*					Apt #*		
City					Zip Code	*	
Demographic information below is not required to receive food.							
Phone Number		$() - \Box Home \Box Work \Box Cell$					
	Email						
Gross Household Income		Weekly / Bi-weekly / Monthly / Yearly					
Gender		\Box Female \Box Male					
Ethnicity		□ African American/Black □ Native American/Native Alaskan □ Asian □ Native Hawaiian/Pacific Islander □ Caucasian/White □ Other □ Hispanic/Latino (a) □ Decline to State					
	ary Language		1				
Additional Questions: Is anyone in your household?		Veteran □ Yes □ No			meless es □ No	Active Military or Dependent □ Yes □ No	
Household Public Benefits		Disability	\Box CalFresh \Box S	ocial Security	y 🗆 Medicare/Medi-Cal		
Other Household Members List*							
First Name*		Last Name*	Date of Birth*	Gender	Eth	nicity	Relationship *
² OOD Food Bank's database	By signing this form, I am confirming that the information provided is accurate. I understand that the information provide be entered into a secure, password-protected database that may be shared between all nonprofit food service providers, I San Diego, and the Jacobs & Cushman San Diego Food Bank. Information collected is for statistical reporting and fund purposes and will remain confidential. I understand that I cannot hold liable any organization for the food products obtained at this site; it is my discretion when not to consume the food products. Signature Date						
<u>ц</u>							
OTHER SERVICES 2-1- 1 database	I have read the CIE authorization on reverse side and by providing my signature and date below, I agree to these terms. Signature Date						

* Field with an Asterisk is a mandatory field.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION



Community Information Exchange

You are authorizing the Jacob and Cushman San Diego Food Bank and the Infoline of San Diego County, dba Community Information Exchange (CIE) and its Partner Agencies to use, store and share your personal, financial and health information with each other in order to assess your needs, coordinate your care and provide services to you. Partner Agencies participating in the CIE are listed at <u>www.211sandiego.org</u>.

This Authorization covers, without restriction, all information disclosed and re-disclosed to CIE by you, your family, Partner Agencies including your care team, or any other person involved in your care while this Authorization is in effect. CIE and its Partner Agencies may share your personal, financial and health information. You agree to notify CIE if your information changes or is incorrect. Information disclosed pursuant to this Authorization may be re-disclosed and no longer be protected under applicable privacy laws. However, your information will still be protected under our Participation Agreement with our partners. Your refusal to sign this Authorization will not adversely affect your ability to receive health care or services from Referral Agencies directly.

Notice of Privacy Practices posted at www.211sandiego.org explains how CIE uses and protects information, how to get a copy of this Authorization and your record. You can revoke this authorization at any time by sending notice to CIE at revoke@211sandiego.org, allowing a minimum of **five business** days to process. Revocation will not affect any information previously disclosed in reliance on this Authorization. Unless revoked earlier, this Authorization will Ten (10) Years, the following expire in or on Date:

If you agree, sign your name below:

Signature