

**Chicken Soup Brigade Food and Nutrition Services Application**

**Please mail completed forms to:**

**Chicken Soup Brigade PO Box 80547, Seattle, WA 98108**

**or fax to (206) 860-6326**

**or call our Client Services Team (206) 957-1686**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_**

**Preferred/Former Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred method of contact (**please circle one**): Phone  Email Letter**

**How did you hear about Chicken Soup Brigade/Referral Source:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have or has a doctor told you that you have one of the following diagnoses? (**Please check all that apply**)**

**High Blood Pressure  High Cholesterol  Pre-Diabetes Diabetes Cancer  Congestive Heart Failure  Heart Disease  COPD  HIV Multiple Sclerosis  Kidney Disease**

**On Dialysis? Yes  No**

**Depression  Anxiety**

**Other diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender (**please circle**):**

**Male**  **Female**  **Trans M to F or F to M  Gender Non-Conforming**

**Race (**Please circle**): American Indian/Alaska Native  Asian**

**Black/African American  Native Hawaiian/Other Pacific Islander  White**

**Ethnicity (**Please circle**): Non-Hispanic/Latino**  **Hispanic/Latino**

**Are you a Veteran? (**Please circle**):**  **Yes**  **No**

**Are you a refugee/immigrant (**Please circle**):**  **Yes**  **No**

**Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you need an interpreter? (**Please circle**): Yes  No**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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