

**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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