Baltimore City Health Department - Division of Aging and CARE Services

Membership Form

ETIB Participant YES / NO

SITE NAME : _____

UPT Card # : _____

Last Name (Required):		First Name (Required):	Social Security Number:
Date of Birth (Required):	Gender: ___ Male ___ Female	Date Joined Center: Date Joined ETlB:	Signature (Required): X
Street Address:	Apt#:	Telephone Number/Cell Phone:	Do you live alone? YES / NO Number in Household?
City:	State / Zip code:	Are you a Volunteer? YES / NO I Volunteer for: _____	I am interested in becoming a Volunteer. YES / NO I would like to Volunteer for: _____
Emergency Contact Name:		Contact Telephone Number:	Nutritional Form Completed YES / NO Consent Form Signed YES / NO

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Race:
___ African American
___ American Indian / Alaskan
___ Asian
___ Hawaiian/Pacific Islander
___ White
___ Other

Ethnicity: ___ Hispanic ___ Non-Hispanic ___ Unknown

Individual Income: ___ Above $990/month ___ Below $990/month Couples Income: ___ Above $1,335/month ___ Below $1335/month

Please complete the registration form in its entirety.

PRIVACY CONSENT FORM

The information you put on this form will be used to (1) help improve programs for seniors, or (2) find out if you qualify for other programs. It may be shared with the Maryland Department of Aging ("**MDoA**"), Baltimore City Health Department ("BCHD")-Division of Aging and CARE Services, and Eating Together in Baltimore City ("ETIB").

("BCHD")-Division of Aging and CARE Services, **ETIB**, and the **MDoA** will not voluntarily share any facts that identify you with anyone except people working for them who need the facts to perform their jobs. Facts that identify you include your name, social security number, address, and telephone number.

Please note, if a program is only for people who meet its qualifications (such as age, income, or health condition) and you do not share the facts that show you qualify, then you will not be able to enroll in that program. Program staff can tell you exactly which facts are needed to show you qualify for the Eating Together program.

You may look at a record that identifies you. You may do this to make sure the facts are correct. To look at such a record you must write to BCHD-Division of Aging and CARE Services, 417 E. Fayette Street, 6th Floor, Baltimore, MD 21202.

*Please **sign** and **date** below to show that you have read and understand the Privacy Consent Form. Thank you.*

X _____ **X** _____

(Signature) (Date)