

- Information collected will only be used within the Oregon Food Bank Network of pantries and remain anonymous to all outside parties.
 - This information will not be shared with the government or be used to restrict the services you receive. No services will be denied if you choose not to share some or all of this information.
- Oregon Food Bank, Marion Polk Food Share and this pantry are an equal opportunity provider. Thank you for your help.

a. When did you first access food assistance? (Estimation ok): Date: _____

b. Last name: _____ c. First name: _____

d. Date of Birth: ____ / ____ / ____ (mm/dd/yyyy) e. Is this birth date estimated? Yes No

f. Gender: Female ⁰² Male ⁰¹ Transgender ⁰³ Other ⁰⁵ Undisclosed ⁰⁴

g. Marital status: Single ⁰¹ Common-Law ⁰² Separated ⁰³ Undisclosed ⁰⁴
 Married ⁰⁵ Divorced ⁰⁶ Widowed ⁰⁷

h. Address: _____

i. Address (Line 2): _____ j. County: _____

k. City: _____ l. State: _____ m. Zip code: _____

No fixed address/ Undisclosed

n. What is your current housing type? (Select one)

- | | | |
|--|---|---|
| <input type="checkbox"/> Camping ⁰¹ | <input type="checkbox"/> Vehicle ⁰⁶ | <input type="checkbox"/> Private Rental / Renting ¹² |
| <input type="checkbox"/> Halfway House ⁰² | <input type="checkbox"/> Warming Facility ⁰⁷ | <input type="checkbox"/> Public (Social) Housing ¹³ |
| <input type="checkbox"/> Mobile Home ¹⁶ | <input type="checkbox"/> Emergency Shelter/
Mission/Transitional ⁰⁸ | <input type="checkbox"/> With Family/Friends ¹⁴ |
| <input type="checkbox"/> Motel/Hotel ⁰³ | <input type="checkbox"/> Evacuee ⁰⁹ | <input type="checkbox"/> Youth Home / Shelter ¹⁵ |
| <input type="checkbox"/> Residential Treatment Facility or
Supervised Housing ⁰⁴ | <input type="checkbox"/> Own Home ¹¹ | <input type="checkbox"/> Unhoused ¹⁰ |
| | | <input type="checkbox"/> Undisclosed ⁰⁵ |

o. Email Address: _____

p. Phone Number: _____

(You will only be contacted if there is important information regarding services)

q. What Language(s) are spoken in your household? (Select all that apply)

- English ⁰¹ Spanish ⁰² Somali ⁰³ Vietnamese ⁰⁴ Russian ⁰⁵ Mandarin ⁰⁶
 Hindi/Urdu ⁰⁷ Arabic ⁰⁸ Other: _____ ¹⁰

r. What is your Ethnicity? (Select all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> White/Anglo ⁰¹ | <input type="checkbox"/> Asian ⁰³ | <input type="checkbox"/> N/A (None) ⁰⁸ |
| <input type="checkbox"/> Black / African American ⁰⁵ | <input type="checkbox"/> Alaska Native/ Aleut / Eskimo ⁰⁷ | <input type="checkbox"/> Other ¹⁰ |
| <input type="checkbox"/> Hispanic/Latino ⁰² | <input type="checkbox"/> Middle-Eastern / North-African ⁰⁴ | <input type="checkbox"/> Undisclosed ⁰⁹ |
| <input type="checkbox"/> American Indian/Native American ⁰⁶ | <input type="checkbox"/> Pacific Islander ¹¹ | |

s. Do you identify as any of the following? (Select all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Developmental Disability ⁰¹ | <input type="checkbox"/> Pregnant ⁰⁴ | <input type="checkbox"/> Veteran ⁰⁵ |
| <input type="checkbox"/> Disability ⁰² | <input type="checkbox"/> Postpartum ⁰⁷ | <input type="checkbox"/> PTSD ¹³ |
| <input type="checkbox"/> Mental Illness ⁰³ | <input type="checkbox"/> Breastfeeding ⁰⁸ | <input type="checkbox"/> Other ¹⁰ |
| | <input type="checkbox"/> N/A (None) ¹¹ | <input type="checkbox"/> Undisclosed ¹² |

(Please flip over to the back)

(Data entry: switch to add household members then return to back side)

t. **What was your highest education level completed?** (Select one)

- | | | |
|--|--|--|
| <input type="checkbox"/> Grades 0-8 ⁰¹ | <input type="checkbox"/> Post-Secondary (Some) ⁰⁵ | <input type="checkbox"/> 4-Year Degree ⁰⁸ |
| <input type="checkbox"/> Grades 9-11 ⁰² | <input type="checkbox"/> Trade School / Professional Accreditation ⁰⁶ | <input type="checkbox"/> Master's Degree ⁰⁹ |
| <input type="checkbox"/> High School Diploma ⁰³ | <input type="checkbox"/> 2-Year Degree ⁰⁷ | <input type="checkbox"/> PhD ¹⁰ |
| <input type="checkbox"/> GED ⁰⁴ | | <input type="checkbox"/> Undisclosed ¹¹ |

u. **What is your current employment type?** (Select one)

- | | | |
|---|--|--|
| <input type="checkbox"/> Military ⁰¹ | <input type="checkbox"/> Full-Time ⁰⁷ | |
| <input type="checkbox"/> Multiple Jobs ⁰² | <input type="checkbox"/> Part-Time ⁰⁸ | |
| <input type="checkbox"/> Seasonal ⁰⁴ | <input type="checkbox"/> Retired ⁰³ | |
| <input type="checkbox"/> Self-Employed ⁰⁵ | <input type="checkbox"/> Other ¹¹ | |
| <input type="checkbox"/> Post-Secondary Student ⁰⁶ | <input type="checkbox"/> None ⁰⁹ | <input type="checkbox"/> Undisclosed ¹⁰ |

v. **What is your income type?** (Select main sources of income for your household)

- | | | |
|---|--|--|
| <input type="checkbox"/> Full-Time Employment ⁰⁴ | <input type="checkbox"/> Child Support ⁰⁹ | |
| <input type="checkbox"/> Part-Time Employment ⁰⁶ | <input type="checkbox"/> Retirement or Pension ⁰⁸ | |
| <input type="checkbox"/> Multiple Jobs ⁰⁵ | <input type="checkbox"/> Social Security Benefits ¹⁸ | |
| <input type="checkbox"/> Day Labor ⁰² | <input type="checkbox"/> Social Security Disability Insurance (SSDI) ¹⁹ | |
| <input type="checkbox"/> Farm related work ⁰³ | <input type="checkbox"/> Supplemental Security Income (SSI) ²¹ | |
| <input type="checkbox"/> Self-Employment ⁰⁷ | <input type="checkbox"/> Student Financial Aid ¹¹ | |
| <input type="checkbox"/> Unemployment Benefits ¹² | <input type="checkbox"/> Tribal Funds ²⁵ | <input type="checkbox"/> No Income ⁰¹ |
| <input type="checkbox"/> Family/Friends Support ¹⁰ | <input type="checkbox"/> Worker's Compensation or SAIF ¹³ | <input type="checkbox"/> Undisclosed ²³ |

w. **Does your household currently receive any of the following?** (Select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Energy Assistance ¹⁴ | <input type="checkbox"/> TANF (Temporary Assistance for Needy Families) ²⁴ |
| <input type="checkbox"/> Free or Reduced Lunch ¹⁵ | <input type="checkbox"/> Vet's Aid or Armed Forces ¹⁶ |
| <input type="checkbox"/> Medicaid (Oregon Health Plan in Oregon) ²² | <input type="checkbox"/> WIC (Assistance for Women, Infants, and Children) ²⁰ |
| <input type="checkbox"/> Medicare ²⁶ | <input type="checkbox"/> SNAP (Oregon Trail card in Oregon /Formally known as Food Stamps) ¹⁷ |

x. **Does anyone in your household have any dietary considerations?** (Select all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Dairy Allergy/Sensitivity ⁰¹ | <input type="checkbox"/> Low Sodium ⁰⁷ | <input type="checkbox"/> Soy Allergy/ Sensitivity ¹² |
| <input type="checkbox"/> Dental Concerns ⁰² | <input type="checkbox"/> No Pork ¹⁶ | <input type="checkbox"/> Tree Nuts Allergy/ Sensitivity ¹³ |
| <input type="checkbox"/> Diabetic ⁰³ | <input type="checkbox"/> No or Limited Cooking Equipment ⁰⁸ | <input type="checkbox"/> Vegan ¹⁴ |
| <input type="checkbox"/> Egg Allergy/Sensitivity ⁰⁴ | <input type="checkbox"/> Other ⁰⁹ | <input type="checkbox"/> Vegetarian ¹⁵ |
| <input type="checkbox"/> Gluten Allergy/Sensitivity ⁰⁵ | <input type="checkbox"/> Peanut Allergy ¹⁰ | <input type="checkbox"/> None ¹⁷ |
| <input type="checkbox"/> Kosher / Halal ⁰⁶ | <input type="checkbox"/> Seafood Allergy/Sensitivity ¹¹ | |

Primary person's Last Name: _____ First Name: _____

Additional Household Members: (Please list each person you share this food with below and on the back side)

a. Last name: _____		b. First name: _____	
c. Date of Birth: ____/____/____ (mm/dd/yyyy)		d. Is this birth date estimated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Gender: <input type="checkbox"/> Female ₀₂ <input type="checkbox"/> Male ₀₁ <input type="checkbox"/> Transgender ₀₃ <input type="checkbox"/> Other ₀₅ <input type="checkbox"/> Undisclosed ₀₄			
f. This person is your... <input type="checkbox"/> Spouse ₀₁ <input type="checkbox"/> Common-Law Partner ₀₉ <input type="checkbox"/> Child ₀₂ <input type="checkbox"/> Parent ₀₃			
<input type="checkbox"/> Sibling ₀₄ <input type="checkbox"/> Grandchild ₀₅ <input type="checkbox"/> Grandparent ₀₆ <input type="checkbox"/> Other Relative ₀₇ <input type="checkbox"/> Ward ₁₄			
<input type="checkbox"/> Boyfriend/Girlfriend ₀₈ <input type="checkbox"/> Friend ₁₀ <input type="checkbox"/> Roommate ₁₃ <input type="checkbox"/> Other ₁₂ <input type="checkbox"/> Undisclosed ₁₁			
g. What is their Ethnicity? <input type="checkbox"/> White/Anglo ₀₁ <input type="checkbox"/> Asian ₀₃ <input type="checkbox"/> Black / African American ₀₅			
<input type="checkbox"/> Alaska Native/ Aleut / Eskimo ₀₇ <input type="checkbox"/> Hispanic/Latino ₀₂ <input type="checkbox"/> American Indian / Native American ₀₆			
<input type="checkbox"/> Middle-Eastern / North- African ₀₄ <input type="checkbox"/> Pacific Islander ₁₀ <input type="checkbox"/> N/A (None) ₀₈ <input type="checkbox"/> Other ₁₁ <input type="checkbox"/> Undisclosed ₀₉			
h. Do they identify with any of the following?: <input type="checkbox"/> Pregnant ₀₃ <input type="checkbox"/> Veteran ₀₉			
<input type="checkbox"/> Developmental Disability ₀₁ <input type="checkbox"/> Postpartum ₀₇ <input type="checkbox"/> PTSD ₁₃			
<input type="checkbox"/> Disability ₀₅ <input type="checkbox"/> Breastfeeding ₁₁			
<input type="checkbox"/> Mental Illness ₀₄ <input type="checkbox"/> Other ₁₀ <input type="checkbox"/> N/A (None) ₀₈ <input type="checkbox"/> Undisclosed ₁₂			
a. Last name: _____		b. First name: _____	
c. Date of Birth: ____/____/____ (mm/dd/yyyy)		d. Is this birth date estimated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Gender: <input type="checkbox"/> Female ₀₂ <input type="checkbox"/> Male ₀₁ <input type="checkbox"/> Transgender ₀₃ <input type="checkbox"/> Other ₀₅ <input type="checkbox"/> Undisclosed ₀₄			
f. This person is your... <input type="checkbox"/> Spouse ₀₁ <input type="checkbox"/> Common-Law Partner ₀₉ <input type="checkbox"/> Child ₀₂ <input type="checkbox"/> Parent ₀₃			
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<input type="checkbox"/> Boyfriend/Girlfriend ₀₈ <input type="checkbox"/> Friend ₁₀ <input type="checkbox"/> Roommate ₁₃ <input type="checkbox"/> Other ₁₂ <input type="checkbox"/> Undisclosed ₁₁			
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<input type="checkbox"/> Middle-Eastern / North- African ₀₄ <input type="checkbox"/> Pacific Islander ₁₀ <input type="checkbox"/> N/A (None) ₀₈ <input type="checkbox"/> Other ₁₁ <input type="checkbox"/> Undisclosed ₀₉			
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<input type="checkbox"/> Disability ₀₅ <input type="checkbox"/> Breastfeeding ₁₁			
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<input type="checkbox"/> Disability ₀₅	<input type="checkbox"/> Breastfeeding ₁₁		
<input type="checkbox"/> Mental Illness ₀₄	<input type="checkbox"/> Other ₁₀	<input type="checkbox"/> N/A (None) ₀₈	<input type="checkbox"/> Undisclosed ₁₂

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