FOOD SHARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES THE MONTHLY WITHDRAWAL OF FUNDS FOR A CONTRIBUTION FOR HOME DELIVERED OR CONGREGATE MEALS FROM THE FOOD SHARE ACCOUNT OF:



(This information will be kept confident Address	Name		Card Number	
City, State, Zip			(This information will be kept confid	ential)
Amount: \$per meal OR \$per month Beginning with the meal served on, Date & continuing every month on the 16 th or the next business day until the below signed gives notice to stop. Signed	Address		4-Digit PIN Number	
Beginning with the meal served on	City, State, Zip			
Beginning with the meal served on, Date & continuing every month on the 16th or the next business day until the below signed gives notice to stop. Signed Date	Amount: \$	_per meal OR \$	per month	
& continuing every month on the 16th or the next business day until the below signed gives notice to stop. Signed	Beginning with the mea	l served on	<i></i>	
stop. Signed			Date	
		ith on the 16th or the n	ext business day until the below signed gives notice	to
Date	Signed			
	Date			

The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with the federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your records and request change to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff.

Fiscal Staff submits to Food Share monthly after the HDM statements are created. Also sends participant a

ADRC of Eagle Country

Food Share invoice & copy of HDM statement.

1-877-794-2372

www.adrceagle.org

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