

# SNAP



## Enrollment Agreement

**Enrollment:** The information contained on this Enrollment Form is true and correct to the best of my knowledge.

I understand that it is extremely important to keep my enrollment information up-to-date. I will update my enrollment information promptly if my health changes significantly. I understand that my enrollment must be updated annually. I understand that I will receive an annual reminder to update my SNAP enrollment information.

I understand participation in SNAP is voluntary. I will only be included in SNAP with my permission.

**Personal Preparedness:** Registration does not guarantee priority assistance after a disaster. Rescue workers must care for victims as they are discovered. All residents should plan to be self-sufficient for at least two to five days with supplies including food, water, and medications. I understand that I am responsible for any prescription medications, oxygen supplies, medical equipment, and special dietary items that I may require during a disaster.

**Permissions:** I hereby authorize Public Health Solutions District Health Department to share the information I submitted in the event of a local disaster. Information will only be shared with emergency response agencies and disaster recovery related agencies, such as human service agencies, as needed. When Public Health Solutions District Health Department activates emergency operations some or all of the enrollment information collected may be shared on a need to know basis with the organizations that will be actively responding to the disaster.

I hereby give local law enforcement, search and rescue, and/or medical personnel permission to enter my home in the event of a local disaster.

**Release of Liability:** I hereby agree to indemnify, defend, and hold harmless Public Health Solutions District Health Department, its officers, agents and employees from and against claims, damages, losses and expenses, including but not limited to attorney's fees, arising out of or resulting from performance of this Enrollment Agreement and Terms of Service, to the fullest extent permitted by law, that results in any claim for any injury to or destruction of tangible or intangible property, including any loss of use resulting there from, and that are caused in whole or in part by the intentional or negligent act or omission related to Public Health Solutions District Health Department.

**Security of Personal Information:** Public Health Solutions District Health Department does not sell, rent, or publish enrollment information. Enrollment information will not be revealed to any unaffiliated third parties for their independent use, except if required by law.

**My rights:** As an individual enrolled in SNAP, I have the right to:

- Examine my enrollment information to ensure it is accurate and up-to-date
- Be informed of any unauthorized violation of privacy
- Know of any changes in policy related to the privacy of my information
- Withdraw from SNAP at any time and have all my enrollment information completely removed

**Voluntary Agreement:** I hereby voluntarily agree to the terms herein and request to be enrolled in the Public Health Solutions Disaster Registry.

Registrant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Other signature, if the registrant is unable to sign: \_\_\_\_\_  
Date \_\_\_\_\_

- I obtained verbal permission.
- I have the legal authority, specify: \_\_\_\_\_  
Initial \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Mail to: Public Health Solutions District Health Department  
995 E. Hwy 33, Suite 1  
Crete, NE 68333

Phone: 402-826-3880  
Fax: 402-826-4101  
Toll Free: 1-888-310-0565  
Email: [registry@phsneb.org](mailto:registry@phsneb.org)

Website: [www.phsneb.org](http://www.phsneb.org)

We're on the web at [www.phsneb.org](http://www.phsneb.org)

