California Secretary of State

safe at home
California's Confidential Address Program

California Address Confidentiality Program
加州地址保密計畫

Safe at Home Reproductive Healthcare Enrollment Application
Safe at Home 生殖健康照護登記申請

- This application is five (5) pages. This form must be entirely completed with an application assistant at an enrolling agency to be accepted. All sections are required unless otherwise noted.
  此申請包含五 (5) 頁。此表格必須由登記機構的申請助理完整填寫。除非另有說明，否則所有節皆必需填寫。
- Contact Safe at Home at (877) 322-5227 with questions related to this application.
  如有與此申請相關的問題，請致電 (877) 322-5227 聯絡 Safe at Home。
- **It is a misdemeanor to provide false information on this application. (Gov. Code §6215.2(g))**
  在此申請中提供虛假資訊屬於輕罪。(政府法典 §6215.2(g))
- The enrolling agency application assistant must mail completed forms and required documents to: Safe at Home, P.O. Box 846, Sacramento, CA, 95812.
  登記機構申請助理必須將填妥的表格和所需文件郵寄至：Safe at Home, P.O. Box 846, Sacramento, CA, 95812。

SECTION 1: APPLICANT INFORMATION
第 1 節：申請人資訊

You must provide your full legal name. If you do not have a middle name, write "none."
您必須提供您的法定全名。如果您沒有中間名，請填寫「無」。

First Name: 名字：	Middle Name: 中間名：
Last Name: 姓氏：	
Gender: 性別： ☐ Male 男性 ☐ Female 女性 ☐ Non-Binary 非二元性別	Date of Birth: / / 出生日期：
Preferred Phone Number: ( ) - 常用電話號碼：	
Email (optional): 電子郵件 (選填)：	
Applicant Type: 申請人類型： ☐ Provider 提供者 ☐ Employee 員工 ☐ Volunteer 志工 ☐ Patient 患者 ☐ Dependent adults or incapacitated person 受撫養的成年人或喪失行為能力者 If also enrolling members that **reside in** your household, check all that apply: 如果也登記了**居住於**您家中的成員，請勾選所有適用選項： ☐ Minor child or children 未成年子女 ☐ Household member 家庭成員	
If enrolling members in your household, please clearly write full name and birthdate of each and the phone number for adult household members: 如果您正在登記家庭成員，請清楚填寫每名家庭成員的全名和出生日期以及成年家庭成員的電話號碼：	
Do you have a disability for which you need reasonable accommodation to communicate with Safe at Home? 您是否為殘障人士，需要合理便民服務才能與 Safe at Home 溝通？	☐ Yes 是 ☐ No 否
If yes, what type? 如回答「是」，屬於什麼類型？	☐ Hearing 聽力 ☐ Vision 視覺 ☐ Other 其他

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Please describe the reasonable accommodation(s) needed in the space below: 請於下方空白處說明所需的合理便民服務：
☐ **Reproductive Healthcare Provider/Employee/Volunteer** have provided documentation showing that the individual is to commence employment or is currently employed as a provider or employee at a reproductive health care services facility or is volunteering at a reproductive health care services facility. (Gov. Code §6215.2(a)(1)(A)) **生殖健康照護提供者/員工/志工**已提供文件表明該個人將開始就業或目前受僱為生殖健康照護服務機構的服務提供者或員工，或正於某設施擔任生殖健康照護志工。(政府法典 §6215.2(a)(1)(A)) - If a volunteer, documentation must show length of time the volunteer has committed to working at the facility. (Gov. Code §6215.2(a)(2)) 如果是志工，文件必須顯示志工承諾於該設施工作的時間長度。(政府法典 §6215.2(a)(2)) ☐ **Reproductive Healthcare Patients** have provided any police, court or other government agency records or files that show any complaints of the alleged threats or acts of violence. (Gov. Code §6215.2(a)(3)(B)) **生殖健康照護患者**已提供任何的警察、法院或其他政府機構的記錄或文件，以顯示對所謂的威脅或暴力之投訴。(政府法典 §6215.2(a)(3)(B))

SECTION 2: ADDRESS AND CONTACT INFORMATION
第 2 節：地址和聯絡資訊

You must provide the residence address where you currently live. Do not provide a post office box or a rented mailbox.
您必須提供您目前居住的居住地址。請勿提供郵政信箱或租用的郵箱。

Residence Address: 居住地址：		Apartment/Unit: 公寓/單元：
City: 城市：	State: 州：	ZIP Code: 郵遞區號：
County: 郡：		

You must provide your mailing address if different from your residence address. A post office box or rented mailbox is allowed as your mailing address. Safe at Home will forward your mail to this location.
如果您的郵寄地址與居住地址不同，必須提供郵寄地址。您可以使用郵政信箱或租用的郵箱作為您的郵寄地址。Safe at Home 會將您的郵件轉寄到此位置。

☐ Same as residence address (skip to facility address information) 與居住地址相同(跳至設施地址資訊)		
Mailing Address: 郵寄地址：		Apartment/Unit: 公寓/單元：
City: 城市：	State: 州：	ZIP Code: 郵遞區號：

You must provide the name and address of the reproductive healthcare facility where you are a provider, employee, volunteer, or patient.
您必須提供您作為服務提供者、員工、志工或患者所在的生殖健康照護設施之名稱和地址。

Name of reproductive healthcare facility: 生殖健康照護設施名稱：		
Address: 地址：		County: 郡：
City: 城市：	State: 州：	ZIP Code: 郵遞區號：

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SECTION 3: APPLICANT AGREEMENT/ACKNOWLEDGEMENT
第 3 節：申請人同意/確認

Applicants MUST agree to and confirm the following to enroll in the program. Please initial each statement and provide a full signature and the date in the space below.
申請人必須同意並確認以下內容才能登記該計畫。請於每份聲明上草簽並於下方空白處提供完整的簽名和日期。

	I designate the Secretary of State as agent for purposes of service of process and for the purposes of receipt of mail. (Gov. Code §6215.2(a)(4)) 本人指定州務卿作為代理人，用於送達程序和接收郵件。(政府法典 §6215.2(a)(4))
	The Secretary of State may terminate my participation in the Safe at Home program if I am enrolling as a provider, employee, or volunteer and fail to disclose a change in employment, or termination as a volunteer or provider. (Gov. Code§6215.4(b)(5)) 如果本人作為服務提供者、員工或志工登記並且未披露就業變動或作為志工或服務提供者之終止，州務卿可能會終止本人參與 Safe at Home 計畫。(政府法典 §6215.4(b)(5))
	The Secretary of State may terminate my participation in the Safe at Home Program and invalidate my authorization card if a service of process document or mail forwarded to the program participant by the Secretary of State is returned as non-deliverable. (Gov. Code §6215.4(b)(4)) 如果國務卿轉寄給計畫參與者的送達程序文件或郵件因無法送達而被退回，國務卿可能會終止本人參與 Safe at Home 計畫並使本人的授權卡失效。(政府法典 §6215.4(b)(4))
	I understand that if I provide false information, or if I falsely state on an application that disclosure of my address would endanger my safety, the safety of a minor child or children, or the incapacitated person on whose behalf this application is made, or if I knowingly provide false or incorrect information on this application, I may be guilty of a misdemeanor. (Gov. Code §6215.2(g)) 本人明白，如果本人提供虛假資訊，或者本人於該申請中虛假聲明披露地址將危害本人、一名或多名未成年子女的安全，或者代表該申請的喪失行為能力者的安全，或者本人故意在此申請中提供虛假或不正確的資訊，本人將犯有輕罪。(政府法典 §6215.2(g))
	I am applying for the Safe at Home program because I am a reproductive healthcare service provider, employee, volunteer or patient and I am in fear for my safety, or for that of my family or the incapacitated person on whose behalf this application is made, because of my affiliation with a reproductive health care services facility. (Gov. Code §6215.2(a)(1)(C)) 本人將申請 Safe at Home 計畫，因為本人為生殖健康照護服務提供者、員工、志工或患者，本人擔心自身安全，或者本人家人或代表本人提出此申請的喪失行為能力者的安全，因為本人隸屬於生殖健康照護服務設施。(政府法典 §6215.2(a)(1)(C)) ~or~ ~或~ I am applying for the Safe at Home program because I, or the minor or incapacitated person on whose behalf the application is made, have been the target of threats or acts of violence because I obtained or I am seeking to obtain services at a reproductive health care services facility. (Gov. Code §6215.2(a)(3)(A)) 本人將申請 Safe at Home 計畫，因為本人或代表本人提出申請的未成年人或喪失行為能力者已經成為威脅或暴力的施加目標，因為本人已獲得或正在尋求獲得生殖健康照護服務設施之服務。(政府法典 §6215.2(a)(3)(A))
▶Signature: 簽名：	Date: / / 日期：

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SECTION 4: CERTIFIED STATEMENT / RESTRAINING ORDER (Must Select One)
第 4 節：認證聲明/禁止令（必須選擇一項）

☐ Certified Statement by Authorized Representative (Gov. Code §6215.2(b)(1)(B)(i))
授權代表的認證聲明（政府法典 §6215.2(b)(1)(B)(i)）

By signing below, I certify that the reproductive healthcare provider, employee, volunteer, or patient completing this application is or was the target of threats or acts of violence within one year of the date of application.

本人於下方簽名，證明在申請之日起一年內，填寫此申請的生殖健康照護提供者、員工、志工或患者是（或曾是）威脅或暴力的施加目標。

Name of Reproductive Healthcare Facility: 生殖健康照護設施名稱：	
Facility Phone Number: ( ) - 設施電話號碼：	
Printed Name of Authorized Representative: 授權代表工整書寫姓名：	
Job Title: 職稱：	
►Authorized Representative Signature: 授權代表簽名：	Date: / / 日期：

☐ Certified Statement by Reproductive Healthcare employee, patient, or volunteer (Gov. Code §6215.2(a)(1)(B)(ii))
生殖健康照護員工、患者或志工的認證聲明（政府法典 §6215.2(a)(1)(B)(ii)）

By signing below, I certify that I have been the target of threats or acts of violence or harassment within one year of the date of application because of my association with the reproductive healthcare services facility.

本人於下方簽名，證明在申請之日起一年內因本人與生殖健康照護服務設施之隸屬關係而成為威脅或暴力或騷擾的施加目標。

►Signature: 簽名：	Date: / / 日期：

☐ Workplace Violence Restraining Order Attached (Gov. Code §6215.2(a)(1)(B)(iii))
隨附工作場所暴力禁止令（政府法典 §6215.2(a)(1)(B)(iii)）

Attached order must be based upon threats or acts of violence connected to the applicant's affiliation with the reproductive healthcare services facility or the minor or incapacitated person on whose behalf the application is made.

隨附命令必須基於申請人與生殖健康照護服務設施之隸屬關係或代表其提出申請的未成年人，或喪失行為能力者的工作相關之威脅或暴力。

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SECTION 5: ENROLLING AGENCY INFORMATION
第 5 節：登記機構資訊

This section MUST be completed by an application assistant at a designated enrolling agency with an original signature. If this section is left blank the enrollment form will NOT be accepted.
此節必須由指定登記機構的申請助理填寫，並附帶原始簽名。如果此部分空白則無法受理此報名表。

Name of Enrolling Agency: 登記機構名稱：		County: 郡：
Address of Enrolling Agency: 登記機構地址：		Suite/Unit: 套房/單元：
City: 城市：	State: 州：	ZIP: 郵遞區號：
Enrolling Agency Phone Number: 登記機構電話號碼：		
Enrolling Agency Email: 登記機構電子郵件：		
Name of Application Assistant: 申請助理姓名：		
►Applicant Assistant Signature: 申請人助理簽名：		Date: / / 日期：

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