California
Secretary of State

safe at home
Confidential Address Program
CALIFORNIA SECRETARY OF STATE

Safe at Home
Designated Health Care Services
(Reproductive and Gender-Affirming Health Care Services)
Enrollment Application

- This form must be fully completed with an application assistant at an enrolling agency to be accepted. All sections are required unless otherwise noted.
- One application per adult applicant is required.
- "Designated health care services provider, employee, volunteer, or patient" means a gender-affirming health care or a gender-affirming mental health care provider, employee, volunteer, or patient, or a reproductive health care services provider, employee, volunteer, or patient. (Gov. Code §6215.1(c))
  - On this form "designated health care services" will be used to mean gender-affirming health care, gender-affirming mental health care, or reproductive health care.
- Contact Safe at Home at (877) 322-5227 with questions related to this application.
- Applicants should review the Supplemental Information for details about the required application fee and acceptable payment methods.
- **It is a misdemeanor to provide false information on this application. (Gov. Code §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.

SECTION 1: APPLICANT INFORMATION

You must provide your full legal name. If you do not have a middle name, write "none."

First Name:	Middle Name:
Last Name:	
Gender: ☐ Male ☐ Female ☐ Non- Binary	Date of Birth: / /
Preferred Phone Number: ( ) -	
Email (optional):	

Applicant Type (select only one):
Primary Applicant: ☐ Enrolling Self Only ☐ Enrolling self and minor child(ren)
☐ Enrolling adult incapacitated person (Form SAH-2B must also be submitted)
Family Member Applicant: ☐ Enrolling as an adult family member ☐ Enrolling adult incapacitated person as an adult family member (Form SAH-2B must also be submitted)

Designated Health Care Eligibility Type (Not required for Family Member Applicants):
☐ Gender-Affirming Health Care or Mental Health Care Provider, Employee, Volunteer, or Patient
☐ Reproductive Health Care Services Provider, Employee, Volunteer, or Patient

If you are enrolling minor children, please clearly write full name and birthdate of each:

This section should be left blank for Family Member Applicants.

☐ **Designated Health Care 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 designated health care services facility or is volunteering at a designated health care services facility. (Gov. Code §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))

☐ **Designated Health Care 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))

SECTION 2: ADDRESS AND CONTACT INFORMATION

You must provide the residence address where you currently live. Do not provide a post office box or a rented mailbox.

Residence Address:		Apartment/Unit:
City:	State:	ZIP Code:
County:		

Check the box below if your mailing address is the same as your residential address. Otherwise, provide your mailing address below. A post office box or rented mailbox is allowed as your mailing address. Safe at Home will forward your mail to this location.

☐ Same as residence address		
Mailing Address:		Apartment/Unit:
City:	State:	ZIP Code:

You must provide the name and address of the designated health care services facility where you are a provider, employee, volunteer, or patient. (Not required for Family Member Applicants)

Name of facility:		
Address:		County:
City:	State:	ZIP Code:

SECTION 3: FAMILY MEMBER APPLICANT ONLY (This section should be left blank for Primary Applicants.)

*Please complete this section with information on the **Primary Applicant** (the person who is a designated health care services provider, employee, volunteer, or patient and is in fear for their and/or their family's safety). Provide the Primary Applicant's full legal name. If there is no middle name, write "none" in the middle name box.*

First Name:	Middle Name:
Last Name:	
ID Number (if assigned):	

SECTION 4: APPLICANT AGREEMENT/ACKNOWLEDGEMENT

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.

	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))
	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))
	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))
	For Primary Applicant Only: 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 volunteer or provider. (Gov. Code §6215.4(b)(5).) If this does not apply, enter N/A in the box.
	I am applying for the Safe at Home program because I am a designated health care services 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 designated health care services facility. (Gov. Code §6215.2(a)(1)(C)) ~or~ 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 designated health care services facility. (Gov. Code §6215.2(a)(3)(A))
▶ Signature:	Date: / /

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SECTION 5: CERTIFIED STATEMENT OR RESTRAINING ORDER (This section should be left blank for Family Member Applicants.)

Primary Applicants must select one of the following:

☐ Certified Statement by Authorized Representative (Gov. Code §6215.2(a)(1)(B)(i))

By signing below, I certify that the designated health care services 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.

Name of Designated Health Care Services Facility:	
Facility Phone Number: ( ) -	
Printed Name of Authorized Representative:	
Job Title:	
► Authorized Representative Signature:	Date: / /

☐ Certified Statement by designated health care services provider, employee, volunteer, or patient (Gov. Code §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 designated health care services facility.

► Signature:	Date: / /

☐ Workplace Violence Restraining Order Attached (Gov. Code §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 designated health care services facility or the minor or incapacitated person on whose behalf the application is made.

SECTION 6: ENROLLING AGENCY INFORMATION

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.

Name of Enrolling Agency:		County:
Address of Enrolling Agency:		Suite/Unit:
City:	State:	ZIP:
Enrolling Agency Phone Number:		
Enrolling Agency Email:		
Name of Application Assistant:		
► Applicant Assistant Signature:		Date: / /