<u>NOTICE TO ALL PANTRY CLIENTS</u>

In order to receive a **FULL BOX** all documents listed below are required:

- Completed Application
- Photo ID (can be expired) for all adult members over the age of 18 living in the home. This includes family, friends, roommates, or other people; anyone living in your home.
- Proof of income for **<u>the previous 30 days before application</u>** for every member living in the home, this includes family, friends, roommates, or others. Anyone living in your home.

Bank statements will not be accepted as proof of income. They only show net income, and we need gross.

Even if you are unemployed but receive money from another source…we need this proof of income to record in your file. This is considered income.

<u>THANK YOU FOR YOUR COOPERATION</u>
Uintah Basin Food Pantry Advisory Board

We are an equal opportunity provider. Any accommodation including auxiliary aids and services are available upon request to individuals with disabilities by calling (435) 722-4518 at least 3 days prior to your appointment. Individuals with speech and/or hearing impairments may call the Relay Utah by dialing 711, and/or Spanish Relay Utah: 1-888-346-3162 for assistance.

BASIN ASSOCIATION OF GOVERNMENTS

Uintah Basin Association of Governments Centralized Intake & Consent Form

PLEASE COMPLETE INFORMATION TO THE BEST OF YOUR KNOWLEDGE

TODAY'S INTAKE DATE: ____________________

Household Size	Monthly income limit at 185%	Monthly income limit at 200%
1	$2321.75	$2510.00
2	$3151.17	$3406.67
3	$3980.58	$4303.33
4	$4810.00	$5200.00
5	$5639.42	$6096.67
6	$6468.83	$6993.33
7	$7298.25	$7890.00
	185% ADD $829.42 for each additional HH member	200% ADD $896.67 for each additional HH member

LIVING ARRANGEMENT: ☐Rent $__________ ☐Rent Subsidized $__________ ☐Own $__________ ☐With Friends/Family $__________ ☐Homeless ☐Temporary Quarters ☐Other __________

DOES ANYONE IN YOUR HOUSEHOLD HAVE?

Food Stamps ☐ Yes ☐ No $__________
WIC ☐ Yes ☐ No
Free School Lunch ☐ Yes ☐ No
Medicaid ☐ Yes ☐ No

____
Address P.O.

______________________ UT ______________
City State Zip Code

APPLICANT

____
LAST NAME FIRST NAME INITIAL

PHONE # ______________________________

SOCIAL SEC #: ___ ___ ___-___ ___-___ ___ ___ ___ ☐ Refused

DATE OF BIRTH ______/______/______
MONTH DAY YEAR

GENDER ☐Male ☐Female
DISABILITY ☐Yes ☐No
VETERAN ☐Yes ☐No
CITIZEN ☐Yes ☐No

RACE: ☐Asian ☐Black ☐White ☐ American Indian ☐Pacific Islander ☐Bi-racial ☐Other
Ethnicity: ☐Hispanic or Latin ☐**NOT** Hispanic or Latin

FAMILY TYPE: (choose one)
☐Single Person ☐Single Parent/Female ☐Single Parent/Male
☐Two Parent HH ☐Two Adults (no children) ☐ Extended Family
☐Multiple Adults (living w/children) ☐Non Related Adults w/children
☐Multi-Generational ☐ Unspecified/Other

HEALTH INSURANCE ☐ None ☐ Direct Purchase ☐Medicaid
☐ Military ☐Medicare ☐ State Children ☐ State Adult (PCN)
☐ Employment Based ☐Other

EDUCATION: ☐0-8 ☐9-12/Non-Grad ☐12+post-secondary
☐High School Graduate ☐ 2 or 4 year College Grad ☐GED ☐ Grad. Other post-secondary school

Is this person able to work? ☐Yes ☐No

EMPLOYMENT STATUS: ☐ Full Time ☐ Part-Time ☐ Un-Employed
☐Unemployed 6 months or less ☐Seasonal Farm Worker ☐ Retired

INCOME: $__________
☐Weekly ☐Bi-Monthly ☐ Monthly ☐ Annual/Seasonal

Additional Source of Income:

Source	Frequency	Amount

____
LAST NAME FIRST NAME INITIAL

PHONE # ______________________________

SOCIAL SEC #: ___ ___ ___-___ ___-___ ___ ___ ___ ☐ Refused

DATE OF BIRTH ______/______/______
MONTH DAY YEAR

GENDER ☐Male ☐Female
DISABILITY ☐Yes ☐No
VETERAN ☐Yes ☐No
CITIZEN ☐Yes ☐No

RACE: ☐Asian ☐Black ☐White ☐ American Indian ☐Pacific Islander ☐Bi-racial ☐Other
Ethnicity: ☐Hispanic or Latin ☐**NOT** Hispanic or Latin

RELATIONSHIP TO APPLICANT: ☐Spouse ☐Partner ☐Son ☐Daughter ☐Brother ☐Sister ☐Aunt ☐Uncle ☐Grandparent ☐Nephew ☐Grandchild ☐Niece ☐In-Law ☐Father ☐Mother ☐Custodial Parent ☐Step-Child ☐Foster-Child ☐Other

HEALTH INSURANCE ☐ None ☐ Direct Purchase ☐Medicaid
☐ Military ☐Medicare ☐ State Children ☐ State Adult (PCN)
☐ Employment Based ☐Other

EDUCATION: ☐0-8 ☐9-12/Non-Grad ☐12+post-secondary
☐High School Graduate ☐ 2 or 4 year College Grad ☐GED ☐ Grad. Other post-secondary sch.

Is this person able to work? ☐Yes ☐No

EMPLOYMENT STATUS: ☐ Full Time ☐ Part-Time ☐ Un-Employed
☐Unemployed 6 months or less ☐Seasonal Farm Worker ☐ Retired

INCOME: $__________
☐Weekly ☐Bi-Monthly ☐ Monthly ☐ Annual/Seasonal

Additional Source of Income:

Source	Frequency	Amount

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In this section, please include all additional members of the household.

LAST NAME ______ FIRST NAME ______ INITIAL ______

SOCIAL SEC #: ___ ___ ___-___ ___-___ ___ ___ ___ ☐ Refused

DATE OF BIRTH: ________ / ________ / ________
Month / Day / Year

RELATIONSHIP ☐Son ☐Daughter ☐Brother
☐Sister ☐Aunt ☐Uncle ☐Grandparent ☐Nephew
☐Niece ☐Grandchild ☐Father ☐Mother ☐Step-Child
☐ Girlfriend ☐ Boyfriend ☐ Other Non-Family

GENDER	**DISABILITY**	**VETERAN**	**CITIZEN**
☐ Male	☐ No	☐ No	☐ No
☐Female	☐ Yes	☐ Yes	☐ Yes

RACE:
☐Asian ☐Black ☐ White ☐ American Indian
☐Pacific Islander ☐ Bi-racial ☐Other

Ethnicity: ☐Hispanic or Latin ☐**NOT** Hispanic or Latin

EDUCATION: ☐0-8 ☐9th-12/non-Grad ☐12+ post-secondary ☐High School Graduate ☐ 2 or 4 year College Grad ☐GED ☐ Grad. Other post-secondary school

Is this person able to work? ☐Yes ☐No

Employment: ☐ Full Time ☐ Part-Time ☐ Un-Employed
☐Unemployed 6 months or less ☐Seasonal Farm Worker
☐ Retired

Total Monthly Income $:________________
SOURCE: ________________

HEALTH INSURANCE: ☐ None ☐ Direct Purchase ☐Medicaid
☐ Military ☐Medicare ☐ State Children ☐ State Adult (PCN)
☐ Employment Based ☐Other

LAST NAME ______ FIRST NAME ______ INITIAL ______

SOCIAL SEC#: ___ ___ ___-___ ___-___ ___ ___ ___ ☐ Refused

DATE OF BIRTH: ________ / ________ / ________
Month / Day / Year

RELATIONSHIP ☐Son ☐Daughter ☐Brother
☐Sister ☐Aunt ☐Uncle ☐Grandparent ☐Nephew
☐Niece ☐Grandchild ☐Father ☐Mother ☐Step-Child
☐ Girlfriend ☐Boyfriend ☐ Other Non-Family

GENDER	**DISABILITY**	**VETERAN**	**CITIZEN**
☐ Male	☐ No	☐ No	☐ No
☐Female	☐ Yes	☐ Yes	☐ Yes

RACE:
☐Asian ☐Black ☐ White ☐ American Indian
☐Pacific Islander ☐ Bi-racial ☐Other

Ethnicity: ☐Hispanic or Latin ☐**NOT** Hispanic or Latin

EDUCATION: ☐0-8 ☐9th-12/non-Grad ☐12+ post-secondary ☐High School Graduate ☐ 2 or 4 year College Grad ☐GED ☐ Grad. Other post-secondary school

Is this person able to work? ☐Yes ☐No

Employment: ☐ Full Time ☐ Part-Time ☐ Un-Employed
☐Unemployed 6 months or less ☐Seasonal Farm Worker
☐ Retired

Total Monthly Income: $________________
SOURCE: ________________

HEALTH INSURANCE: ☐ None ☐ Direct Purchase ☐Medicaid
☐ Military ☐Medicare ☐ State Children ☐ State Adult (PCN)
☐ Employment Based ☐Other

LAST NAME ______ FIRST NAME ______ INITIAL ______

SOCIAL SEC #: ___ ___ ___-___ ___-___ ___ ___ ___ ☐ Refused
DATE OF BIRTH: ________ / ________ / ________
Month / Day / Year

RELATIONSHIP ☐Son ☐Daughter ☐Brother
☐Sister ☐Aunt ☐Uncle ☐Grandparent ☐Nephew
☐Niece ☐Grandchild ☐Father ☐Mother ☐Step-Child
☐ Girlfriend ☐ Boyfriend ☐ Other Non-Family

GENDER	**DISABILITY**	**VETERAN**	**CITIZEN**
☐ Male	☐ No	☐ No	☐ No
☐Female	☐ Yes	☐ Yes	☐ Yes

RACE:
☐Asian ☐Black ☐ White ☐ American Indian
☐Pacific Islander ☐ Bi-racial ☐Other

Ethnicity: ☐Hispanic Or Latin ☐**NOT** Hispanic or Latin

EDUCATION: ☐0-8 ☐9th-12/non-Grad ☐12+ post-secondary ☐High School Graduate ☐ 2 or 4 year College Grad ☐GED ☐ Grad. Other post-secondary school

Is this person able to work? ☐Yes ☐No

Employment: ☐ Full Time ☐ Part-Time ☐ Un-Employed
☐Unemployed 6 months or less ☐Seasonal Farm Worker
☐ Retired

Total Monthly Income: $________________
SOURCE: ________________

HEALTH INSURANCE: ☐ None ☐ Direct Purchase ☐Medicaid
☐ Military ☐Medicare ☐ State Children ☐ State Adult (PCN)
☐ Employment Based ☐Oth

"I, ______________________, give Uintah Basin Association of Government consent to release, obtain, and share all pertinent identifying and non-confidential social and other information about myself and dependents that will allow me to benefit from services offered. In granting such permission, I understand that such information will remain confidential and that such information will only be used for my benefit or to benefit other members of my family. Only authorized personnel will share client information needed for service delivery, and program eligibility. **The statements made by me on this consent form are true, correct, and complete to the best of my knowledge."**

Customer Signature: ______________________ Date: __________ Staff Signature: ______________________ Date: __________

Authorization for Use & Disclosure of Information

Community Services Department

Section A	Legal Last Name	First	MI	Date of Birth	Social Sec. # (optional)
	Other Names Used By Client / Applicant			Phone #	

By signing this form, I authorize the following record holder (individual, school, employer, agency, medical or other provider) to disclose the following specific confidential information about me:

Section B	Release From:	Specific Information to be Disclosed	Mutual Exchange: Yes/No
	○ Department of Workforce Services ○ Northeastern Counseling ○ Active Re-Entry ○ Other: ____________________ ○ Other: ____________________	○ Income and source of income ○ Social Security Numbers ○ Information about previous assistance ○ Picture I.D.	

Section C	Release To (address required if mailed) If releasing to a team, list members	Purpose	Expiration Date or Event*
	Uintah Basin Association of Governments	Obtaining assistance through this agency.	
	330 East 100 South		
	Roosevelt, Utah 84066		
	Attention: Kim Dieter		

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protect information about my case. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnoses, treatment, or referral information.

Section D	Full Legal Signature of Individual OR Legal Representative	Relationship to Client	Date
	Name of Legal Representative (print)		Date

***The authorization is valid for _____ months from the date of signing unless otherwise specified.**

Case Manager Signature	Date

THE UINTAH BASIN ASSOCIATION OF GOVERNMENTS
COMMUNITY SERVICES CLIENT CODE OF ETHICS

The primary mission of the Uintah Basin Association of Governments Community Services program is to provide shelter, utility, medical, tuition and other emergency services to low-income eligible clients in need to help them become more self-sufficient. "Clients" is used inclusively to refer to individuals and those applying for services. The Uintah Basin Association of Governments Community Services Department will provide clients with accurate and complete information regarding the extent and nature of the current services available to them.

The Uintah Basin Association of Governments Community Services Department will respect and protect the appropriate privacy of records and information concerning clients and will not disclose such information to un-authorized personnel or use it for personal purposes without the client's written consent unless there is appropriate authorization and compelling legal or professional reasons.

They will be held accountable for personal inappropriate misbehavior on their part and that of the Uintah Basin Association of Governments Community Services Department and staff reserves the right to institute consequences for such behavior.

The Uintah Basin Association of Governments considers all applications without regard to race, color, sex, age, or national origin. If you have any questions, concerns or complaints about your services you may call the Program Director of the Uintah Basin Association of Governments.

Grievance Procedures:

UBAOG seeks to provide a fair and objective procedure for handling client grievances. Clients who feel they have a grievance are entitled to seek relief without fear of restraint, reprisal, interference, coercion, or discrimination.

A "grievance" is a complaint by a client concerning the interpretation of policy, procedures, and/or conditions of personal treatment that have not been satisfactorily resolved in an informal manner between the client and offending party. Grievances by clients are to be addressed as follows: a.) Verbal or written with the Program Director; b.) if not resolved, provide a written letter to the Executive Director.

I've read and understand the Client Code of; Ethics for the Uintah Basin Association of Governments Community Services application process and agree to comply.

_______________________________ Client Signature

_______________________________ Date

Uintah Basin Association of Governments
Food Pantries

The Uintah Basin Food Pantries allow a client to receive **one** food box every **month**. You are also allowed two emergency boxes a year (within 12 months).
Initial ________

In order to set up a file and receive a full monthly box, you must supply photo identification (can be expired) for all adult members living in your household, proof of all income for the past 30 days including; child support, social security, dividends, state assistance etc… any money you have received during the last 30 days.
Initial ________

When coming in to pick up your box, please bring bags or boxes to put your food in as the pantry doesn't always have anything to put your food in. Bring a friend or family member to help you carry items to your car, if you are unable to do so yourself. Initial ________

Any client that is rude, belligerent, or inappropriate in any way will be asked to leave and can be denied services. Initial ________

Signed: ______________________________ Date: __________________

"Unlimited" / Front Shelves Agreement

I ______________________________ Understand that the front shelves and unlimited items are a privilege. I agree to read and follow the signs that state how much I am allowed to take. For items that are "unlimited" please note that the Food Pantry wants you to have what you need and will use, however please remember to leave something for the next person.

Signed: ______________________________ Date: __________________

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