

NOTICE TO ALL PANTRY CLIENTS

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 **the previous 30 days before application** for every member living in the home, this includes: Family, friends, roommates, or other. Anyone living in your home.

USDA ONLY box can be obtained through self-declaration.

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.

THANK YOU FOR YOUR COOPERATION

Uintah Basin Food Pantry Advisory Board

We are an equal opportunity agency. Any accommodations 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.



Utah 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 150%	Monthly income limit at 185%
1	\$1,595	\$1,967
2	\$2,155	\$2,658
3	\$2,715	\$3,349
4	\$3,275	\$4,039
5	\$3,835	\$4,730
6	\$4,395	\$5,421
7	\$4,955	\$6,111
	150% ADD \$560.00 for each additional HH member	185% ADD \$691 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

Mailing 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 9-12th + 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 9-12th + 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



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 Male No Yes
 Female Yes No

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

Ethnicity: Hispanic or Latin NOT Hispanic or Latin

EDUCATION: 0-8 9th-12th + 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

"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 dependants 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: _____

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 Male No Yes
 Female Yes No

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

Ethnicity: Hispanic or Latin NOT Hispanic or Latin

EDUCATION: 0-8 9th-12th + 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



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
	<input type="checkbox"/> Department of Workforce Services <input type="checkbox"/> North Eastern Counseling <input type="checkbox"/> Turning Point Shelter <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Income and source of income <input type="checkbox"/> Social Security Numbers <input type="checkbox"/> Information about previous assistance <input type="checkbox"/> Picture I.D. <input type="checkbox"/> Checking/ Savings accounts	

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 330 East 100 South Roosevelt, Utah 84066 Attention:	Obtaining assistance through this agency.	

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 _____ from the date of signing unless otherwise specified.**

Case Manager Signature	Date
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**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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