ST. LUCIE COUNTY

FECHA: / / 2018

Only One Membership Required per Household

Last 4 digits of Social Security
___ ___ ___ ___

Apellido:

Nombre:

Direccion: Apt#

Cuidad: Estado: Postal:

Condado: St Lucie Indian River Martin Otro:

Fecha De Nacimiento: Tele:

em@il :

Raza (Circule una) **Negro** **Blanco** **Hispano** **Haitiano** **Asiatico** **Indu** **Otro**

Numero De Personas en Hogar 1 2 3 4 5 6 7 8 9

(Circule una) Empleado Desempleado Trabajo Indemnización Hogar

Fuente De Ingreso ** REQUIRED **

Empleo	Mensual $	
Seguro Social	Mensual $	
Beneficio Desempleo	Mensual $	
Manutención De Hijo	Mensual $	
Desempleado	Mensual $	
EBT (Comida Beneficios)	Mensual $	
Ingreso total Del Hogas*	$	

Favor De Tener Foto

ID

Disponible

EU Ciudadano Si o No

Autorización Conductor Si o No

Veterano Si o No

Casado Soltero Divorciado Seperado Vuida/Vuido

I certify that I am eligible by the standards of Community Food & Outreach Center for services. Eligibility is determined by the income eligibility chart posted at the Welcome Desk. This chart is for determining that I am living at or below the 200% of poverty level. I hereby verify that the info provided is correct and that I am currently living at the address I entered above. I give CFOC permission to share this information with other agencies for the sole purpose of better serving my needs for one year.

Signature **X** _____ Date:_____

UAP Staff Signature_____ Date:_____