MEMBER SHARE GROCERY PROGRAM FORM

DATE | IDENTIFICATION #

DATE OF BIRTH | UP STAFF NAME

NAME

First:	**Middle:**
Last:	**Suffix:**

ADDRESS

Street:	
City:	**State:**
Zip:	**County:**
Phone:	**Email:**

HOUSEHOLD SIZE

Adults	
Children	

HOMELESS

Yes	
No	

VETERAN STATUS

Yes	
No	

FEMALE HEAD OF HOUSEHOLD

Yes	
No	

GENDER **(Select all applicable)**

	Female
	Male
	A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)
	Transgender
	Questioning
	Prefer not to answer

RACE **(Select all applicable)**

	American Indian, Alaska Native, or Indigenous
	Asian or Asian American
	Black, African American, or African
	Native Hawaiian or Pacific Islander
	White
	Prefer not to answer

ETHNICITY

	Non-Hispanic/ Non-Latin(a)(o)(x)
	Hispanic/Latin(a)(o)(x)
	Client does not know
	Prefer not to answer

ALL HOUSEHOLD INCOME

Employment	**$**
Social Security Retirement	**$**
SSI/SSDI Benefits	**$**
Child Support	**$**
Unemployment	**$**
SNAP Benefits	**$**
Veteran Benefits	**$**
TOTAL HOUSEHOLD INCOME	**$**

MORE INFORMATION ON UP PROGRAMS

Yes	
No	

I certify that I am eligible by the standards of United Against Poverty, Inc. (UP) 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. I give UP permission to share this information with other agencies for the sole purpose of better serving my needs for two years from the date of this application.

Signature **X** _____ Date:_____

UAP Staff Signature: _____ Date: _____

Created by JS 04/04/22