ULSTER COUNTY COMMUNITY ACTION COMMITTEE, INC.
70 Lindsley Ave., Kingston, NY 12401 (845) 338-8750

FOR UCCAC Use Only
Date:
in household:
of children:

Intake and Data Collection Application

→TO BE COMPLETED BY THE CUSTOMER: Today's Date: _____

Name: (Last, First, MI)		**Date of Birth:**		**Age Band:** check one below: 0-5 ☐ 18-24 ☐ 55-69 ☐ 6-13 ☐ 25-44 ☐ 60-64 ☐ 14-17 ☐ 45-54 ☐ 65-74 ☐ Unknown ☐ 75+ ☐
Address:		**Gender:** (M/F/Other/Unknown)		
City, ST, Zip:		**Disabled:** (Y/N/Unknown)		
Telephone #:		**# in Household:**		
Monthly Income:	$		**County:** (please check one) **Ulster** ☐ **Sullivan** ☐	

→ SERVICES BEING REQUESTED BY THE CUSTOMER: Primary Language Spoken in the Home: _____

	✓		✓		✓		✓
Weatherization		Emergency Food Pantry		Health Insurance		Thrift Store	
EmPower		Transportation (Med or Regular)		Housing Assistance		Employment Assistance	
Head Start		Utility Assistance		VITA Tax Services		Immigration Assistance	
Early Head Start		Dress for Success		HEAP Assistance		Other:	

→ CHECK THE FOLLOWING OPTIONS THAT PERTAIN TO YOUR BACKGROUND AND/OR FAMILY SITUATION OF THE CUSTOMER:

Race:	✓	**Household Type:**	✓	**Education:**	✓	**Housing:**	**Enter Amounts Below:**
African-American/Black		Single Parent/Female		0-8th Grade		Renter: $	
Caucasian/White		Single Parent/Male		9th – 12th (non-Grad)		Owner: $	
Hispanic/Latino		Two Parent Household		HS Graduate		Homeless: (Y/N)	
Native American/Alaska Native		Single Person		GED		Other, specify below:	
Asian		2 Adults & No Children		12+/Post HS Training		**Ethnicity:** ✓	
Native Hawaiian/other Pacific Islander		Non-related adults with children		Some (2-4yrs) College		Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins ☐ Unknown ☐	
Other		Multigenerational Household		College Graduate		**Work Status: (individuals 18 yrs+)**	
Multi-Race (2 or more)		Other		Unknown			Yes No
Health Insurance Sources:		Unknown		**Other Characteristics:**		Employed Full-Time: ☐ ☐	
Medicaid		Employment Based		Farmer		Employed Part-Time: ☐ ☐	
Medicare		Unknown		Migrant Farm Worker		Unemployed >= 6 mons ☐ ☐	
State Children's Health Insurance Program		**Household Size:**		Seasonal Worker		Unemployed <= 6 mons ☐ ☐	
State Health Insurance for Adults		Single Person		Teen Parent		Unemployed (not in labor force) ☐ ☐	
Military Healthcare		Two		Military (Active) Veteran		Retired: ☐ ☐	
		Three				**Disconnected Youths:**	
Direct-Purchase		Four or More: (specify)		Military Service Unknown		Youths ages 14-24 who are neither working or in school _____	

Source Household Income:	✓		✓
Income from Employment Only		No Income	
Employment & other Income Source		Non-Cash Benefits	
Employment, Other & Non-Cash Benefits		Unknown	
Employment & Non-Cash Benefits			
Other Income Source Only			
Other Income & Non-Cash Benefits			

Non-Cash Benefits:	✓	**Other Income Source:**	✓
SNAP		TANF	

WIC		Supplemental Security Income (SSI)	
LIHEAP		Social Security Disability Income (SSDI)	
Housing Choice Voucher		VA Service-Connected Disability Compensation	
Public Housing		VA Non-Service Connected Disability Pension	
Permanent Supportive Housing		Private Disability Insurance	
HUD-VASH		Workers' Compensation	
Childcare Voucher		Retirement Income from Social Security	
Affordable Care Act Subsidy		Pension	
Other		Child Support	
Unknown		Alimony or other spousal support	
		Unemployment Insurance	
		EITC	
		Other	
		Unknown	

→ Other Household Member Information from the Customer: **(DO NOT INCLUDE YOURSELF!)**

Name:	DOB:	Relationship	M/F	Disabled (Y/N)	Ethnicity	Education Level	SNAP	Health Ins.	Vet (Y/N)	Source of Income ($)

Because your personal information is held in the strictest of confidence, we will only share information with a signed ***RELEASE OF INFORMATION*** form (included in this package).

DECLARATION

I, the undersigned customer, do solemnly swear that the above information is true, correct and complete to the best of my knowledge. I understand that any false statements or misrepresentation may result in my being found ineligible for program participation, up to an including termination from a program. I consent to any inquiries to verify or confirm the information provided on this application.

Signature of Customer:		Date:	

TO BE COMPLETED BY UCCAC, INC., EMPLOYEES <----------

Med Card Copy:		Both sides of medical card copied. Medical Provider:
Level of Income: % of Federal Poverty Level	✓	If over the 125%: _____ Outreach Funds _____ Other sources (Please list)
Under 75%		
Under 100%		
Under 125%		Care Managers/Program Director's Initials: _____ Date: _____
Under 150%		***A United Way member Agency serving Ulster County since 1965 and now in Sullivan County since 2017!***
Over 150%		