Program Registration Form FY 2021

theUpperRoom
a family resource center

Staff Use Only

_____

Staff Initials

S	D	F

To be completed for each program participant—adults and children *Please Print Clearly*

Date Registered_____

Program: GDJD ☐ CH ☐ CSLO ☐ TC ☐ YES ☐ R8 ☐ PACC ☐ YAS ☐ GDFO ☐ TIPS ☐ TT ☐ HiSet ☐ PCS ☐ Kinship ☐ Food ☐

Parent Ed ☐ *Which class:*_____ Have you participated in any other Upper Room programs? Yes ☐ No ☐

PARTICIPANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ DOB _____ Age _____

Town _____ State _____ Zip Code _____

Email*_____ Telephone (Cell ☐ Home ☐) (_____)_____

☐ * I do NOT wish to be put on the email list.

If a minor—custodial parent/guardian name _____

Participant is: Married ☐ Single ☐ Other ☐ _____

PLEASE ANSWER *ALL* QUESTIONS BELOW

Do you have health insurance? Yes ☐ No ☐

If yes choose all applicable:

Private ☐ Name of Company:_____

Medicare ☐

Medicaid ☐ Choose one:

Wellsense ☐ NH Healthy Families ☐ Other ☐

Primary Insurer: Self ☐ Spouse ☐ Parent/Guardian ☐

What is your race:

- ☐ Alaskan Native/ Native American
- ☐ African American/Black
- ☐ Asian
- ☐ Caucasian/White
- ☐ Native Hawaiian/Pacific Islander
- ☐ More than one

Other:_____

***AND:* What is your Ethnicity? ☐ Non-Hispanic ☐ Hispanic**

Is your primary language English? ☐ Yes ☐ No

What is your Gender (please write in):_____

Are you Employed? FT ☐ PT ☐ Not Employed ☐

Are you a Student? FT ☐ PT ☐ Not a Student ☐

Are you a U.S. Citizen? Yes ☐ No ☐

If 18 or older, are you a US Veteran or active US Military? Yes ☐ No ☐

Under 18, is your Parent/Guardian a US Vet or active US Military? Yes ☐ No ☐

If pregnant, would you like to receive information/ resources for your pregnancy? Yes ☐ No ☐ N/A ☐

Do you have a disability? Yes ☐ No ☐ Prefer not to answer ☐

HOUSEHOLD INFORMATION

Head of Household Marital Status: Single ☐ Married ☐ Divorced/Seperated ☐ Widowed ☐ Living w/Partner ☐

Other: _____

Household Monthly Income: $_____

TOTAL PEOPLE IN YOUR HOUSEHOLD? #_____ *AND* HOW MANY IN EACH AGE GROUP: _____0-5 _____6-18 _____19-59 _____60 AND OVER

How were you referred to The Upper Room? _____

COMPLETE ONLY WHEN PAYING FOR A SERVICE OR MAKING A DONATION

What is your payment for? Donation ☐ or Program Registration ☐ Which Program? _____

Amount: $_____ Credit Card# _____ Exp. Date _____ CVV#_____

Check# _____ Cash Amount: $_____ Signature: _____

Additional Family Member Information

Date Registered: _____ **Program Name:** _____

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth: ____/_____/_____ **If a minor—custodial parent/guardian name** _____

Participant is: Married ☐ **Single** ☐ **Other** ☐ _____

Do you have health insurance? Yes ☐ No ☐
If yes choose all applicable:
Private ☐ **Name of Company:**_____
Medicare ☐
Medicaid ☐ **Choose one:**
Wellsense ☐ **NH Healthy Families** ☐ **Other** ☐
Primary Insurer: Self ☐ **Spouse** ☐ **Parent/Guardian** ☐

What is your race:
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- ☐ African American/Black
- ☐ Asian
- ☐ Caucasian/White
- ☐ Native Hawaiian/Pacific Islander
- ☐ More than one

Other:_____

AND: **What is your Ethnicity?** ☐ **Non-Hispanic** ☐ **Hispanic**

Is your primary language English? Yes ☐ **No** ☐

What is your Gender (please write in):_____

Are you Employed? FT ☐ **PT** ☐ **Not Employed** ☐

Are you a Student? FT ☐ **PT** ☐ **Not a Student** ☐

Are you a U.S. Citizen? Yes ☐ **No** ☐

If 18 or older, are you a US Veteran or active US Military? Yes ☐ **No** ☐

Under 18, is your Parent/Guardian a US Vet or active US Military? Yes ☐ **No** ☐

If pregnant, would you like to receive information/ resources for your pregnancy? Yes ☐ **No** ☐ **N/A** ☐

Do you have a disability? Yes ☐ **No** ☐ **Prefer not to answer** ☐

Date Registered: _____ **Program Name:** _____

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth: ____/_____/_____ **If a minor—custodial parent/guardian name** _____

Participant is: Married ☐ **Single** ☐ **Other** ☐ _____

Do you have health insurance? Yes ☐ No ☐
If yes choose all applicable:
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Medicare ☐
Medicaid ☐ **Choose one:**
Wellsense ☐ **NH Healthy Families** ☐ **Other** ☐
Primary Insurer: Self ☐ **Spouse** ☐ **Parent/Guardian** ☐

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AND: **What is your Ethnicity?** ☐ **Non-Hispanic** ☐ **Hispanic**

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If pregnant, would you like to receive information/ resources for your pregnancy? Yes ☐ **No** ☐ **N/A** ☐

Do you have a disability? Yes ☐ **No** ☐ **Prefer not to answer** ☐