

EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP) CERTIFICATION OF ELIGIBILITY

Agency Name _____

Agency Number _____

Name: _____ Number of People in Household: _____

Address: _____ Phone: _____

City/State: _____ County: _____

You are eligible to receive food from TEFAP if your household participates in any of the following programs. Please place a checkmark in the space next to the category that applies. *(Sign and date application)*

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance to Needy Families (TANF)
- Individual receiving Supplement Security Income (SSI)
- Individual receiving Medicaid

You are eligible to receive food from TEFAP if your household meets the income guidelines in addition to participating in the Supplemental Security Income (SSI) or Medicaid program. Please place a checkmark in the space next to the category that applies and include income. *(Sign and date application)*

- Individual receiving Supplement Security Income (SSI) with additional HH members include total income _____
- Individual receiving Medicaid with additional HH members include total income _____

You are eligible to receive food from TEFAP if your household meets the income guidelines. Please place total amount of household income in the space next to that applies. *(Sign and date application)*

_____ Weekly _____ Monthly _____ Annual

Please read the following statement carefully and then sign the form and write in today's date.

You only need to meet one of these requirements to be eligible to receive USDA foods.

I certify that I am the only person in this household who has applied for this assistance. I certify that the income of all persons in my household is not more than the amount listed on this form. I understand that I can only receive USDA food once a month. I understand that making a false statement may result in having to pay the state for the value of the food improperly issued to me and may subject me to criminal prosecution under state and federal law.

Signature

Date

THIS CERTIFICATION IS VALID FOR A PERIOD OF ONE YEAR and may be renewed as needed. Any changes in the household's circumstances must be reported to the distributing agency immediately.

OPTIONAL: _____ is authorized to pick up USDA foods on my behalf.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights

1400 Independence Avenue, SW

Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider

Census Information:

Total _____ Children _____ Adults _____ Seniors in the Household

Fredericksburg Regional Food Bank

Service Insights Initiative Software – Link2Feed

RELEASE OF INFORMATION (ROI)



Link2Feed is a shared, computerized record keeping system that captures insights about people experiencing food insecurity in our community. The Fredericksburg Regional Food Bank administers Link2Feed on behalf of our partner agencies participating in the Service Insights Initiative (SII).

Last Name _____ **First Name** _____ **MI** _____
Address _____ **City/State** _____ **Zip** _____
Date of Birth ____ / ____ / ____ **Circle Benefits** Medicaid SNAP SSDI SSI TANF WIC Vets Aid
mm / dd / yyyy
Gender _____ **Monthly Household Income** \$ _____
Primary Income Source _____
Ethnicity _____

Please indicate if anyone in the household self-identifies as one of the following: Active Military (AM), Disabled (D) or Veteran (V)

Individuals In Household	DOB	Gender	Ethnicity	Relationship to Client

Dietary Considerations (Circle all that apply for this household)

Diabetic Egg Allergy Gluten Free Milk Allergy No Pork No Sulphites Peanut Allergy Seafood Allergy
 Soy Allergy Tree Nuts Allergy Vegan Vegetarian Wheat Allergy
Other (Please Specify) _____

X

Customer/Parent-Legal Guardian's Authorizing Signature

Date

X

Agency Representative Signature

Date

By signing the above line, I authorize this agency, as a Service Insights Initiative participant, to share the basic, identifying and non-confidential service information of myself and that of my household with other agencies participating in the SII. This information will remain in the SII's shared system Link2Feed unless I make a formal request to the participating agency that I no longer wish to participate in the SII.

Agency Name: _____