

EMERGENCY FOOD ASSISTANCE PROGRAM

Please Print

Applicant Name: _____ Tel. No.: _____

Name of Spouse or other adult in household: _____

Street Address and City/Town: _____

Mailing Address (if different): _____

Total Number in Household: _____ How many age 60 and over? _____ How many age 18 and under? _____

SECTION I: Program Eligibility

Are you or any member of your household currently eligible for and/or receiving help from any of the following programs? (If so, please check every program which applies to your household.)

Eligible: Yes No

- | | |
|---|--|
| <input type="checkbox"/> Fuel Assistance
<input type="checkbox"/> Women, Infants and Children (WIC)
<input type="checkbox"/> Commodity Supplemental Food Program (CSFP)
<input type="checkbox"/> Temporary Assistance to Needy Families (TANF)
<input type="checkbox"/> Aid to Permanently and Totally Disabled (APTD)
<input type="checkbox"/> Head Start | <input type="checkbox"/> Food Stamps
<input type="checkbox"/> Medicaid (State Welfare)
<input type="checkbox"/> Aid to the Needy Blind
<input type="checkbox"/> Old Age Assistance
<input type="checkbox"/> Subsidized Housing (Rental Subsidy)
<input type="checkbox"/> County, City or Town Welfare |
|---|--|

SECTION II: Income Eligibility

If you placed a checkmark next to at least one program in SECTION I, **DO NOT COMPLETE SECTION II.**

Eligible: Yes No

Is your combined Gross Yearly Household Income at or below the following guidelines?			
1 - \$21,257	3 - \$36,131	5 - \$51,005	7 - \$65,879
2 - \$28,694	4 - \$43,568	6 - \$58,442	8 - \$73,316

I hereby certify that the above information is true and accurate. I understand that it is sought in connection with the receipt of one household allotment of surplus food. This food is not to be sold or exchanged.

 Signature of Recipient

 Date

Please enter the first and last name and age of each household member.
