Catholic Charities Food Pantry
Intake Form

DATE: ______________ DOB __________________ Phone# ________________

LAST NAME: _________________________ FIRST NAME: ___________________

STREET __________________________________ TOWN: ____________________

OF: ADULTS: __________ CHILDREN: __________

INCOME (in thousands of dollars)

10___ 10-14___ 15-19___ 20-29___ 30-49___ 50__

UNEMPLOYMENT__________ DISABILITY__________
WORKING__________ NOT WORKING__________

EMPLOYER: ____

INCOME SUBSIDIES: (check each if applicable)
PA___MEDICAID___FOOD/ST___SCH/LUNCH____WIC____SSI/SSD___NONE___

HOUSEHOLD GENDER/AGE STATISTICS: (Place number of people in household under each category)
M_____ F_____ 0-5Yr_____ 6-18_____ 20-64_____ 65+_____

Indicate: Pregnant:_____ Veteran_____ Receives VA Benefits _____

NATIONALITY: (please circle)
White Black Asian Hispanic Unknown

RELIGION: NC=Not Catholic RC=Catholic Charities
NC_____ RC_____ PARISH (Only If RC) _____________________________

FAMILY COMPOSITION: (Working Age Adults and Minor Children)
(Please circle)
D/M/Child___M/C___D/C___Hus/Wife___Liv/Other Fam__Liv/Unrel___Liv/alone____

NEED/REQUEST: (please circle)

Food Diapers Clothing Other

DISPOSITION: Any notes about disposition

THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP) ELIGIBILTY FORM

This form is to be filled out for each household receiving food from your program at least once annually. A recipient's signature is sufficient declaration of need.

Name		Phone			
Street		City		ZIP	

Please indicate the number of each below, i.e. if two children are in your household enter "2" in the box below Children.

Children (Ages 0-17)	Adults (Ages 18-64)	Seniors (Ages 65+)	Total Household Members

YOU ARE ELIGIBLE TO RECEIVE TEFAP IF ONE OF THE FOLLOWING IS TRUE FOR YOUR HOUSEHOLD:

OPTION 1: Household Income.
The table below shows a yearly gross income for each household size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive USDA Foods through TEFAP.

Household Size	1	2	3	4	5	6	7	8
Annual Income	$25,520	$34,480	$43,440	$52,400	$61,360	$70,320	$79,280	$88,240

*For each additional family member add $8,960.

OPTION 2:
You are also categorically eligible to receive TEFAP commodities if your household participates in any of the following programs. If you participate in any one of these programs, please check the box(s) next to it.

☐ SNAP ☐ WIC ☐ TANF ☐ Medicaid ☐ SSI ☐ Free/Reduced School Meals

By signing below, I declare that my income from all sources does not exceed the income listed above for households with the same number of people as my household OR that my household participates in the program(s) that I have checked on this form. I understand that these records will be held in confidence at this distribution site but may be released to the New York State Office of General Services or the United State Department of Agriculture for review upon their request.

Signature **Date**

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, 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: How to File a Complaint, 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.

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