

**2011-2012 EMERGENCY SUPPLEMENTAL FOOD ASSISTANCE PROGRAM**

**Please Print Clearly**

**Applicant Name: Last \_\_\_\_\_ First \_\_\_\_\_**

**Name of Spouse or other adult in household: Last \_\_\_\_\_ First \_\_\_\_\_**

**Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_**

**Zip Code: \_\_\_\_\_ Tel. Number: (        ) \_\_\_\_\_**

**Mailing Address: (if different) \_\_\_\_\_**

**\*\*\*\*\* Section I: Income Eligibility: \*\*\*\*\***

**Circle the number of people in your household on the list below.**

- |                     |                     |                     |                     |                      |
|---------------------|---------------------|---------------------|---------------------|----------------------|
| 1 person - \$20,147 | 3 people - \$34,281 | 5 people - \$48,415 | 7 people - \$62,549 | 9 people - \$76,683  |
| 2 people - \$27,214 | 4 people - \$41,348 | 6 people - \$55,482 | 8 people - \$69,616 | 10 people - \$83,750 |

**Is your household Gross Yearly Income less than the amount next to the number you circled?**

**Yes \_\_\_\_\_ No \_\_\_\_\_**

**\*\*\*\*\* Section II: Program Eligibility: \*\*\*\*\***

**Are you or any member of your household currently receiving help from any of the following programs? If so, please check every program that applies to your household:**

- |   |  |
|---|--|
| <input type="checkbox"/> Fuel Assistance                                | <input type="checkbox"/> Food Stamps                         |
| <input type="checkbox"/> Women and children (WIC)                       | <input type="checkbox"/> Medicaid / Healthy Kids             |
| <input type="checkbox"/> Temporary Assistance to Needy Families (TANF)  | <input type="checkbox"/> Aid to Needy Blind                  |
| <input type="checkbox"/> Aid to Permanently and Totally Disabled (APTD) | <input type="checkbox"/> Subsidized Housing (Rental Subsidy) |
| <input type="checkbox"/> County, City or Town Welfare                   | <input type="checkbox"/> Commodity Supplemental Food Pgm.    |
| <input type="checkbox"/> Free/Reduced School Meals Assistance           | <input type="checkbox"/> Social Security Income              |
| <input type="checkbox"/> Head Start                                     | <input type="checkbox"/> Other _____                         |

**\*\*\*\*\* Household Information \*\*\*\*\***

**LIST YOUR NAME FIRST, and then all other members of household:**

<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>DATE OF BIRTH</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

**Please list any dietary restrictions on the back.**

**The above information is true and accurate. I understand that it is needed so that I can get one household pantry box of supplemental food weekly. This food is not to be sold or exchanged. I am not currently receiving foods at other pantries. True \_\_\_\_\_ False \_\_\_\_\_**

**Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_**

**PLEASE REMEMBER:**

**NO parking in TCK rear parking lot – Pantry Line is ONE WAY – Bring your own box or laundry basket**