Catholic Social Services
St. Francis House Food Pantry

Administrative Use
L2F Input date:
By:

St. Francis House Food Pantry Application

Completing this application gains you access to the Saint Francis House food pantry's donated food program. Donated foods are available to all clients who wish to access this service regardless of income, race, level of need, or age. To qualify or recertify for the federal program offered by Saint Francis House food pantry (TEFAP and CSFP) you will need to complete additional applications.

Name (last, first) List head of household (HH) first	**DOB** (MM/DD/YY)	**Gender M/F**	**Relation to HH**	**Ethnicity ***	**Disabled** (Y/N)	**Veteran** (Y/N)	**Monthly Income**	**Income Source**	**PFD** (Y/N)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
To add more family members, please take another application									
*Ethnicity	**(W)** White/Anglo, **(B)** Black/African American, **(H)** Hispanic / Latino, **(AN)** Alaska Native / American Indian, **(A)** Asian, **(M)** Middle-Eastern, **(P)** Pacific Islander, **(O)** Other:								

Housing Type:

Own Home	Rental	Emergency Shelter	Public Housing	With Family/Friends	Youth Shelter	Unhoused	Other:

Primary Language:

English	Spanish	Tagalog	Samoan	Korean	Other

Were you referred? (Y / N) If yes, who/what organization referred you:_____

Program Involvement:

CSFP (senior box)	Medicare Medicaid	National School Lunch Program	SNAP (Food Stamps)	Housing Voucher	Public Assistance	SSI / SSDI	TANF	Unemployment	Other

Reason for Visit:

Changes in family	Changes to benefits/asst	Currently Homeless	Debt	Delays in benefits/asst	Loss of benefits	Lost Job
Medical Expenses/Sick	Natural Disaster	Ongoing Need	Other	Unexpected expenses	Wages delayed	Wages/hour insufficient

I certify the information indicated on this application if true and correct to the best of my knowledge.
I understand this information will be used in a confidential manner. Data obtained from this form will be aggregated and may be used for future planning and funding efforts.
We are required by law to report any cases of suspected abuse or neglect of children or vulnerable adults. We are also required to share information about an individual with law enforcement in certain cases, for example, if you cause harm to a member of our staff, another client, or if you damage our property.
I acknowledge the receipt of "Notice of Privacy Practices", "Rights and Responsibilities", and understand how to file a complaint.

Head of Household Signature _____Date:_____

TEFAP Application and Registration

Effective October 1, 2021 through September 30, 2022

Household Information

HOUSEHOLD MEMBERS; Please **CIRCLE** the total number of household and **NAME OF HEAD OF HOUSEHOLD only**

TOTAL PEOPLE IN HOUSEHOLD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
NAME OF HEAD OF HOUSEHOLD															
PHYSICAL ADDRESS															
CITY, STATE & ZIP															
PHONE NUMBER															
PROXY NAME (IF NEEDED)															

INCOME INFORMATION

INCOME: Permanent Fund Dividend; did anyone in your household receive the current year's PFD?
If YES, include the PFD amount received in your Annual Household Income at the time of applying.

Household Size	1	2	3	4	5	6	7	8*
Annual Income	$48,270	$65,310	$82,350	$99,390	$116,430	$133,470	$150,510	$167,550

*For each additional household member, **add $17,040.**

PROGRAMS BENEFITS: Do you receive benefits from any of the following programs, CIRCLE yes or no:

SNAP (FOOD STAMPS)		***TANF/TRIBAL***		***SSI or MEDICAID***		***CSFP or FDPIR***		***NSLP LUNCH FREE/REDUCED***	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

I certify, under penalty of perjury, that the above information is true and correct to the best of my knowledge and that I am eligible to receive USDA Foods according to current income guidelines.

No Signature Required Due to Covid Pandemic

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, religious creed, disability, age, political beliefs, 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, 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: 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.

For intake workers use only: Please print!

Intake Worker Signature (required) _____ **Date:**_____

Eligible ☐ Ineligible-Reason _____