WISE AREA RELIEF MISSION (W.A.R.M.)

Household Application for Food

Section 1 - Application (To be completed by the household member)
By signing below, I certify that:

1. I am a member of the household living at the address provided in Section 2 and that, on behalf of the household, I am applying for food assistance;
2. All information provided to the agency determining my household's eligibility is, to the best of my knowledge and belief, true and correct; and
3. The information provided by the household's "Authorized Representative" (as named below or as authorized on a separate page) is also, to the best if my knowledge, true and correct

Printed Name of Household Member

_____

Signature of Household Member

_____

Date

_____

Section 2- Household Information

How many people live in your house? ☐ Are you the head of household? ☐Yes ☐No

Residential Address (if available)

Address	
City/State/Zip	

If the household receives other assistance, mark the appropriate choice(s) below. No proof is required

☐	Supplemental Nutrition Assistance Program (SNAP)
☐	Temporary Assistance for Needy Families (TANF)
☐	Supplemental Security Income (SSI)
☐	National School Lunch Program (NSLP)
☐	Medicaid

What is the Total Gross Income* (the amount before deductions) of all household members?
Optional if household receives other assistance.

Gross Income	☐ Per Year	☐ Per Month	☐ Per Week
	$		

*Farmers and self-employed persons may report NET Income (the amount after business expenses)

Section 3 – Temporary Crisis Food Need
(To be completed by the recipient agency only if the household is determined ineligible on the basis of Section 2 information)

Is the household in need of temporary, crisis food assistance? ☐Yes ☐No

If yes, document the reason for the crisis	

Section 4 - Agency Documentation

☐Household is INELIGIBLE (Please explain in the "comments" box below)

☐Household is ELIGIBLE based on the following (mark the appropriate options)

☐Low Income ☐Medicaid

☐SNAP ☐TANF

☐SSI ☐NSLP (Free or reduced-price meals)

Certification period is up to twelve months. For crisis food need (Section 3), certification period is up to six months

Give length of certification period if household is eligible.

Beginning:_____ Ending: _____

Comments	

Signature of Agency Official _____

Date _____

USDA Nondiscrimination Statement

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, 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.

o *NEW*

o *UPDATE*

o *FOOD*

o *NO FOOD TODAY*

WISE AREA RELIEF MISSION
Salvation Army, Wise County Unit
APPLICATION FOR ASSISTANCE

DATE _____

COUNTY _____

The information provided below is used by W.A.R.M. to provide assistance. Should you choose not to provide the information requested, we will honor your refusal, but we are not obligated to assist you.

I understand W.A.R.M. reserves the right to refuse service if any of the following apply:

a) Client is perceived to be incapable of conducting business. Examples: substance abuse involved, violent outbursts, verbal and physical confrontations.

b) Falsification of documentation and/or information written or verbal for the purpose of obtaining assistance. Examples: false identification/alias names, exaggeration of family size, false address or misrepresentation of previous or current assistance.

You agree not to hold W.A.R.M. responsible for the outcome of any assistance received or not received from W.A.R.M. or agencies referred to or by W.A.R.M.

HEAD OF HOUSEHOLD

Last Name _____ **First Name** _____ **M.I.** _____

Date of Birth _____ / _____ / _____ **Phone** _____ - _____ - _____ **D.L. or ID#** _____

Social Security # _____ - _____ - _____ **Ethnicity** _____ **Marital Status** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Employer _____ **Date Hired** _____ / _____

Job Description _____ **Salary/Wage per hour** $_____

Previous Employer _____ **Date terminated** _____ / _____

Reason for Leaving _____

SPOUSE or SIGNIFICANT OTHER THAT LIVES IN THE HOUSE

Last Name _____ **First Name** _____ **M.I.** _____

Date of Birth _____ / _____ / _____ **Phone** _____ - _____ - _____ **D.L. or ID#** _____

Social Security # _____ - _____ - _____ **Ethnicity** _____ **Marital Status** _____

Employer _____ **Date Hired** _____ / _____

Job Description _____ **Salary/Wage per hour** $_____

Previous Employer _____ **Date terminated** _____ / _____

Reason for Leaving _____

OTHERS LIVING IN THE HOUSE

First Name	Last Name	Date of Birth	Relation to head	Social Security #

How were you referred to us? _____

Feel free to list any need for your household.

_____

_____

_____

_____

HOUSEHOLD BUDGET

MONTHLY INCOME WHAT YOU BRING HOME	AMOUNT AND HOW OFTEN
Salary	
Workers Comp	
Unemployment	
Odd Jobs	
Social Security	
SSI / SSDI / Disability	
Pension / Retirement	
V.A.	
Child Support Received	
T.A.N.F.	
Food Stamps / SNAP	
Rental Income	
Oil/Gas Royalties	
Other Income	
TOTAL INCOME	

MONTHLY EXPENSES WHAT YOU PAY OUT	AMOUNT AND HOW OFTEN
Rent / Mortgage / Land	
Home Insurance	
Pay child support	
Utilities (Lights, Water, Trash, Atmos, Propane)	
Cell / Telephone / Internet	
Medicines / Doctor Bills	
Medical insurance	
Food	
Car Payment	
Car Insurance	
Gas for the car	
Life or burial insurance	
Credit cards / loans	
Cable, Satellite, Dish, DirecTv	
Probation / Tickets / Parole	
Other Household Expenses	
TOTAL EXPENSES	

I agree that food may not be given to my family more than once every 30 days from W.A.R.M.

I hereby certify that I have paid no money, property, or services for food received, and that the above information is complete and correct.

I/We acknowledge that W.A.R.M. neither raises nor processes the food it distributes. Therefore, W.A.R.M. will not be responsible for the condition of the food it distributes. I understand that the products I receive are donated products and distributed in good faith. I also understand that it is ultimately my responsibility to examine all products before consumption.

Sign _____

Date _____