

### Household Application for USDA Foods/ Solicitud domestica de los alimentos del USDA

The Emergency Food Assistance Program (TEFAP) / El Programa de Asistencia Alimenticia de Emergencia (TEFAP)

Sites may request but must not require proof of information. / Los sitios pueden solicitar pero no deben requerir prueba de informaci6n.

#### Section 1- Certification

#### Seccion 1 - Certificacion

**By signing below, I certify that:**

- (1) I am a member of the household living at the address provided in Section II and that, on behalf of the household, I apply for USDA Foods that are distributed through The Emergency Food Assistance Program;
- (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) if applicable, the information provided by the household's proxy is, to the best of my knowledge and belief, true and correct.

**Al firmar a continuaci6n, certifico que:**

- (1) soy miembro de la unidad familiar que vive en la direcci6n que se da en la Secci6n 11, y que solicito en nombre de la unidad familiar los domestica de alimentos USDA que se distribuidos por el Programa de Asistencia Alimentaria de Emergencia;
- (2) toda la informaci6n que le he dado al departamento que determinara si mi unidad familiar llena los requisitos del programa, es, a mi leal saber y entender, verdadera y correcta; y
- (3) Si corresponde, la informaci6n proporcionada por el apoderado del hogar es, a lo mejor de mi conocimiento y creencia, verdadero y correcto.

**Signature of household member /**

Firma del miembro de la unidad familiar \_\_\_\_\_

Date/Fecha \_\_\_\_\_

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

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y politicas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en ingles), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en alg(m programa o actividad realizados o financiados por el USDA

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, 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.

Las personas con discapacidades que necesiten medios alternativos para la comunicaci6n de la informaci6n def programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de serias americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audici6n o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay **Service** [Servicio Federal de Retransmisi6n] al (800) 877-8339. Ademias, la informaci6n del programa se puede proporcionar en otros idiomas.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at:

<https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>,t 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:

Para presentar una denuncia de discriminaci6n, complete el Formulario de Denuncia de Discriminaci6n del Programa del USDA, (AD-3027) que esta disponible en linea en: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la informaci6n solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario Ueno o carta al USDA por:

- (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](mailto:program.intake@usda.gov).  
This institution is an equal opportunity provider.

- (1) correo: 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; o
- (3) correo electr6nico: [program.intake@usda.gov](mailto:program.intake@usda.gov).

**Esta instituci6n es un proveedor que ofrece igualdad de oportunidades.**

<b>Name of household member/Nombre del miembro de la unidad familiar</b>		<b>Number of household members/Numero de miembros de la unidad familiar</b>
<b>Address (if available)/Direcci6n (si disponible)</b>		
<b>Name of proxy/Nombre de apoderado</b>	<b>Address of proxy/Direcci6n de residencia del apoderado</b>	

Section 3 - Categorical Eligibility

Seccion 3 - Elegibilidad Categorica

- Supplemental Nutrition Assistance Program (SNAP)/Programa de ayuda suplemental de la nutrici6n
- Temporary Assistance for Needy Families (TANF)/Asistencia temporal a familias necesitadas
- Supplemental Security Income (SSI)/Seguridad de ingreso suplementario
- National School Lunch Program (NSLP) (free or reduced-price meals)/Programa nacional de almuerzos escolares (comidas gratis o a precio reducido)
- Medicaid/Medicaid

Section 4 - Income Eligibility

Seccion 4 - Elegibilidad de Ingresos

Total gross income \$	Ingreso bruto total \$
___ per year ___ per month ___ per week	___ por afo ___ por mes ___ por semana

Section 5 - Household Crisis Eligibility

Seccion 5 - Elegibilidad de Crisis del Hogar

If household is eligible for crisis food need, document reason for crisis here./Si el hogar es elegible para la crisis de alimentos necesidad, documenta el motivo de crisis aqui.	
Certification is up to six months. Contact TDA for approval of crisis food need for seven to twelve months. Length of certification: Beginning (month/year): Ending (month/year):	La certificaci6n es de hasta seis meses. Comuniquese con TDA para la aprobaci6n de la crisis de alimentos necesidad de siete a doce meses. Duraci6n de la certificaci6n: Inicio (mes/afo): Final (mes/afo):

Section 6 - Eligibility or Ineligibility

Seccion 6 - Elegibilidad o Inelegibilidad

<input type="checkbox"/> Household is eligible. Length of certification: Beginning (month/year): Ending (month/year):	<input type="checkbox"/> Hogar es elegible. Duraci6n de la certificaci6n: Inicio (mes/afo): Final (mes/afo):
<input type="checkbox"/> Household is ineligible based on Sections 3 and 4. Complete Section 5 if necessary.	<input type="checkbox"/> El hogar no es elegible basado en las secci6nes 3 y 4. Completa la secci6n 5 si es necesario.

Section 7 - Signature and date of CE or site staff

Seccion 7- Firma y fecha de CE o sitio personal

<b>Signature/Firma</b>	<b>Date/Fecha</b>
------------------------	-------------------

- 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:

- Client is perceived to be incapable of conducting business.  
 Examples: substance abuse involved, violent outbursts, verbal and physical confrontations.
- 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ethnicity \_\_\_\_\_ Marital Status \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Date Hired \_\_\_\_ / \_\_\_\_

Job Description \_\_\_\_\_ Salary/Wage per hour \$ \_\_\_\_\_

**SPOUSE or SIGNIFICANT OTHER THAT LIVES IN THE HOUSE**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ethnicity \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Date Hired \_\_\_\_ / \_\_\_\_

Job Description \_\_\_\_\_ Salary/Wage per hour \$ \_\_\_\_\_

**OTHERS LIVING IN THE HOUSE**

<u>First Name</u>	<u>Last Name</u>	<u>Date of Birth</u>	<u>Relation to head</u>	<u>Social Security #</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How were you referred to us? \_\_\_\_\_

Feel free to list any need for your household.

---

---

---

**HOUSEHOLD BUDGET**

INCOME WHAT YOU BRING HOME	MONTHLY AMOUNT
Salary	
Workman's 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	
<b>TOTAL INCOME</b>	

EXPENSES WHAT YOU PAY OUT	MONTHLY AMOUNT
Rent / Mortgage / Land	
Home / Renters Insurance	
Pay child support	
Utilities (Lights, Water, Trash, Atmos, Propane)	
Cell / Land line / Internet	
Medicines / Doctor Bills	
Medical insurance	
Food	
Car Payment	
Car Insurance	
Gas for the car	
Life or burial insurance	
Credit cards / loans	
Streaming Services	
Probation / Tickets / Parole	
Other Household Expenses	
<b>TOTAL EXPENSES</b>	

I agree 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 \_\_\_\_\_