

Household Application for USDA Foods / Solicitud doméstica 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 información.

Section 1 — Household Information

Sección 1 — Información de hogar

Name of household member /Nombre del miembro de la unidad familiar	Number of household members / Número de miembros del hogar
Address (if available) /Dirección (si disponible)	

Section 2 — Categorical Eligibility

Sección 2 — Elegibilidad Categórica

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

Section 3 — Income Eligibility

Sección 3 — Elegibilidad de Ingresos

Total gross income \$ _____	Ingreso bruto total \$ _____
<input type="checkbox"/> per year <input type="checkbox"/> per month <input type="checkbox"/> per week	<input type="checkbox"/> por año <input type="checkbox"/> por mes <input type="checkbox"/> por semana

Section 4 — Household Crisis Eligibility

Sección 4 — Elegibilidad de Crisis del Hogar

If household is eligible for household crisis food needs, document reason for crisis here. ./Si el hogar es elegible para las necesidades es alimentarias del hogar en caso de crisis, documenta el motivo de la crisis aquí.
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Section 5 — Certification

Sección 5 — Certificación

<p>By signing below, I certify that:</p> <p>(1) I am a member of the household living at the address provided in Section 1 and that, on behalf of the household, I apply for USDA Foods that are distributed through The Emergency Food Assistance Program;</p> <p>(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</p> <p>(3) if applicable, the information provided by the household's proxy is, to the best of my knowledge and belief, true and correct.</p> <p>Signature of household member / Firma del miembro del hogar _____</p>	<p>Al firmar a continuación, certifico que:</p> <p>(1) soy miembro del hogar que vive en la dirección que se da en la Sección 1, y que solicito en nombre de la unidad familiar los doméstica de alimentos USDA que se distribuidos por el Programa de Asistencia Alimentaria de Emergencia;</p> <p>(2) toda la información que le he dado al departamento que determinará si mi unidad familiar llena los requisitos del programa, es, a mi leal saber y entender, verdad era y correcta; y</p> <p>(3) Si corresponde, la información proporcionada por el apoderado del hogar es, a lo mejor de mi conocimiento y creencia, verdadero y correcto.</p> <p>Date/Fecha _____</p>
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Sections 6 & 7 must be completed by the CE or the site staff:

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](https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-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.
- This institution is an equal opportunity provider.**

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), 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 algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidad es que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultad es de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el [Formulario de Denuncia de Discriminación del Programa del USDA](https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), (AD-3027) que está disponible en línea 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 información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por:

- (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 electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

Section 6 — Eligibility or Ineligibility

Sección 6 — Elegibilidad o Inelegibilidad

Household is eligible. Length of certification:
Beginning (month/year): _____
Ending (month/year): _____

El Hogar es elegible. Duración de la certificación:
Inicio (mes/año): _____
Final (mes/año): _____

Household is ineligible based on Sections 2 and 3, but qualifies for TEFAP based on Household Crisis Eligibility (Section 4).
Length of certification: Beginning (month/year): _____
Ending (month/year): _____

El hogar no es elegible basado en las secciones 2 y 3, pero califica para TEFAP basado en la elegibilidad de crisis del hogar (Sección 4).
Duración de la certificación: Inicio (mes/año): _____
Final (mes/año): _____

Section 7 — Signature and date of CE or site staff

Sección 7— Firma y fecha del CE o del sitio personal

Signature/Firma _____ Date/Fecha _____

- NEW
- UPDATE
- FOOD
- 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 ____ - ____ - ____ Email address _____

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 ____ - ____ - ____ Email address _____

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	AMOUNT WEEKLY	AMOUNT MONTHLY
Salary		
Workman's Comp		
Unemployment		
Odd Jobs		
Social Security		
SSI / SSDI / Disability		
Pension / Retirement		
V.A.		
Received Child Support		
T.A.N.F.		
Food Stamps / SNAP		
Rental Income		
Oil / Gas Royalties		
Other Income		
TOTAL INCOME		

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

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 _____