First Church Stoneham Food Pantry Client Registration

All information is kept confidential

First Name:	**Last Name:**	**Tel #:**	**Email:**
Street Address:	**Apt #:**	**Stoneham MA 02180**	

Housing: ○ Rent ○ Own ○ Homeless ○ Other:

How did you hear about us: ○ Social Media ○ Food Pantry Client ○ Social Services Agency ○ Other:

Your Reason for Contacting Us (select one)*:* ○ Employed but financially challenged (EFC) ○ Unemployed (UNE)

○ Retired, financially challenged (RFC) ○ Permanently Disabled ○ Temporary Illness (Ill)

Ethnicity: ○ White ○ Asian/Asian Pacific ○ Latino ○ African American / Black ○ Native American

Applicant's Gender: ○ Female ○ Male **Applicant's Age**: ○ 18 – 64 ○ 65 or older

Please list all other individuals in your household.

Full Name	Yearof Birth	Gender	Reason for Need, see explanations above
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A
		○ F ○ M	○ EFC ○ UNE ○ RFC ○ DIS ○ Ill ○ Student ○ N/A

Number of U.S. Veterans in your household:

By signing below, I affirm that I/we do not have the funds to obtain sufficient food for my/our household. I certify that the information provided above is true and understand that providing false information can disqualify me from this program.

Signature: ______________________ Date: 03/08/2022

The Emergency Food Assistance Program (TEFAP) Application/Self-Declaration of Eligibility Form

Our food pantry receives foods from many sources. One of those sources is The Emergency Food Assistance Program (TEFAP), a program managed by the federal government. This program provides foods such as bottled juices, dried & canned fruits, nuts, dried beans, peanut butter, canned fish and meats, dairy products, frozen meats, fresh and frozen fruits and vegetables. You must meet the guidelines in section 2 or 3 to receive this food. If you do not qualify, please date and sign only section 1 of this form.

1. ☐ My household **DOES NOT MEET** the guidelines to qualify for foods from the TEFAP program.

Signature:_____ **Date:**_____

OR

2. ☐ **My household receives government financial assistance. I/we have checked all that apply to my/our household.**

☐ Headstart	☐ Supplemental Security Income (SSI)
☐ LIHEAP (Fuel Assistance)	☐ Temporary Assistance for Needy Families (TANF)
☐ Medicaid	☐ Veterans Aid
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ Women, Infants & Children Nutrition Program (WIC)

OR

3. ☐ The **combined income for all adults in my/our household** is equal to or less than the income level shown for my/our household size.
I have selected the line that applies to my/our Household Size. (Proof of income is not required.)

# of Household Members	*Annual Income*	*Monthly Income*	*Weekly Income*
◯ 1	$ 32,200	$ 2,683	$ 619
◯ 2	$ 43,550	$ 3,629	$ 838
◯ 3	$ 54,900	$ 4,575	$ 1,056
◯ 4	$ 66,250	$ 5,521	$ 1,274
◯ 5	$ 77,600	$ 6,467	$ 1,492
◯ 6	$ 88,950	$ 7,413	$ 1,711
◯ 7	$ 100,300	$ 8,358	$ 1,929
◯ 8	$ 111,650	$ 9,304	$ 2,147
☐ *For each additional household member, add:*	$ 11,350	$ 946	$ 218

By signing below, I certify that my/our total yearly household gross income is at or below the income listed on this form for my/our size household, OR, my/our household members participate in the program(s) that have been checked on this form. I/we also certify that as of today, I reside in the State of Massachusetts.

This certification is being submitted in connection with the receipt of Federal assistance. Program officials may verify what I/we have certified to be true. /wel understand that making a false certification may result in having to pay the State agency for the value of the food improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. I/we understand the requirement to report to the pantry if household income increases over the income amount listed for my/our household size, OR, if my/our household no longer receives government financial assistance.

This certification is valid for a period of up to one YEAR but recertification may be requested by the pantry at any time.

Signature: _____ Date:_____