pennsylvania DEPARTMENT OF AGRICULTURE BUREAU OF FOOD DISTRIBUTION CSFP HUNGER-FREE PENNSYLVANIA A Network of Food Banks & Charitable Organizations

Name of Participant:	Date of Birth: _____ [Participant Must Provide Proof]	◯Male◯Female
Street Address:Apt:	City:	Zip:
Home Phone Number:	Cell Phone Number:	

Total Household Income Amount $ _____ **How many persons live in this household?** _____ (if more than 1, see below)

Household Income Reported is Received [Check One]: ◯Weekly ◯Monthly ◯Annually

Source of Income: ◯Disability ◯Pension ◯Social Security ◯Underemployment ◯Unemployment

Form of ID Provided? ◯Driver's License ◯Birth Certificate ◯Passport ◯PA ID Card ◯Resident Alien Card

Are you Hispanic or Latino? [Check Only One] ◯Yes ◯No

What is your race? [Check All That Apply] ◯American Indian or Alaska Native ◯Asian ◯White ◯Black or African American ◯Native Hawaiian or Another Pacific Islander

ADDITIONAL HOUSEHOLD MEMBERS MUST BE LISTED BELOW:

Household Member	First Name	Last Name	Birthdate	Gender [Circle One]:
1				Male or Female
2				Male or Female
3				Male or Female
4				Male or Female

For additional household members turn over

This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I am also aware that I may not receive both CSFP and WIC benefits simultaneously, and I may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining eligibility for participation in other public assistance programs and for program outreach purposes.

PLEASE INDICATE DECISION BY PLACING A CHECKMARK IN THE APPROPRIATE BOX: ◯YES ◯NO

SignatureofParticipant / Caretaker[CircleOne]:

Caretaker Only - Print Name:

Proxy 1 – Print Name: **Proxy 1 Signature:** **Date:**

Proxy 2 – Print Name: **Proxy 2 Signature:** **Date:**

Site Name:	County:
Site Representative Signature:	Date:

The Non-Discrimination Statement is on the back. Please turn over.

Household Member	First Name	Last Name	Birthdate	Gender Circle One
5				Male or Female
6				Male or Female
7				Male or Female
8				Male or Female

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.

Children (0-17) _____

Adults _____

Seniors (60 and up) _____

pennsylvania
DEPARTMENT OF AGRICULTURE

Bureau of Food Distribution

The Emergency Food Assistance Program (TEFAP)

"Self Declaration of Need"

Effective July 1, 2020 to Jun 30, 2021

Recipient Name

Agency Representative Signature Date

Street Address

Distribution Site Name Number

City State Zip

Distribution Site Location

The Emergency Food Assistance Program is operated in accordance with United States Department of Agriculture (USDA) policy, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. Eligibility is based upon the income guidelines listed below. The recipient circles the entire line that applies to their Household Size, understanding they must be at, or below, the income level indicated to be eligible for program benefits.

Total Household Income (based on 150% of Poverty)

Household Size Circle One	Annual	Monthly	Weekly
1	$ 19,140	$ 1,595	$ 368
2	$ 25,860	$ 2,155	$ 497
3	$ 32,580	$ 2,715	$ 627
4	$ 39,300	$ 3,275	$ 756
5	$ 46,020	$ 3,835	$ 885
6	$ 52,740	$ 4,395	$ 1,014
7	$ 59,460	$ 4,955	$ 1,143
8	$ 66,180	$ 5,515	$ 1,273
For each additional family member add:	$ 6,720	$ 560	$ 129

I understand the household income limitations and hereby certify that my household size and income make me eligible for participation in the program. I also certify that, as of today, my household lives in the area served by Pennsylvania in The Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of Federal assistance.

I UNDERSTAND THAT MAKING A FALSE STATEMENT MAY RESULT IN MY HAVING TO PAY FOR THE VALUE OF THE FOOD IMPROPERLY ISSUED TO ME AND MAY SUBJECT ME TO CRIMINAL PROSECUTION UNDER STATE AND FEDERAL LAW.

Recipient Signature **Date**

Return completed form to your designated county agency. If you are unsure of the correct agency, please call the Bureau at 1-800-468-2433.

THIS FORM IS NOT TO BE ALTERED OR CHANGED IN ANY WAY.

PLEASE REFER TO THE REVERSE SIDE OF THIS DOCUMENT FOR AN IMPORTANT USDA NON-DISCRIMINATION STATEMENT

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, 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.

The Emergency Food Assistance Program
Pennsylvania TEFAP Proxy Form

Date _____

I _____ hereby authorize _____ to pick up my TEFAP Food Package and deliver it to me.

_____ ☐ _____
Client Signature Proxy Signature

_____ ☐ Proxy ID Verified
Pantry Representative

ELDERSHARE REGISTRATION FORM

Central Pennsylvania Food Bank
3908 Corey Road, Harrisburg, PA 17109
[Please Print]

CENTRAL PENNSYLVANIA FOOD BANK
No One Should Be Hungry

Name: _____ **Male** ☐ **Female** ☐ **Date of Birth:** _____

Street Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____

Household Income: _____ **How many persons in the household?** _____
☐ Week ☐ Month ☐ Annual

Source of Income: ☐ Disability ☐ Pension ☐ Social Security ☐ SSI/SSD ☐ Underemployment
☐ Unemployment

Certification Statement

I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge and belief.

Release of Liability

I release the Central Pennsylvania Food Bank, its officers, employees, and volunteers from any liability resulting from the ElderShare distribution and agree to hold them harmless against all liabilities, damages, losses, claims, causes of action and suits of law or inequity or obligation whatsoever arising out of or attributed to any actions during the implementation of the ElderShare program.

PLEASE INDICATE DECISION BY PLACING A CHECKMARK IN THE APPROPRIATE BOX: ☐ YES ☐ NO

Signature of Participant: _____ Date: _____

Signature of Site Representative: _____ Date: _____

Site Name: _____ County: _____

ELDERSHARE PROXY FORM

Central Pennsylvania Food Bank
3908 Corey Road, Harrisburg, PA 17109
[Please Print]

CENTRAL PENNSYLVANIA FOOD BANK
No One Should Be Hungry

I, _____, having been certified as a participant in the ElderShare program and having completed the registration process, hereby appoint the following person or persons to receive distributions of ElderShare Food Packages on my behalf:

Name: _____ **Telephone Number:** _____

Address: _____

Name: _____ **Telephone Number:** _____

Address: _____

Name: _____ **Telephone Number:** _____

Address: _____

Signature of ElderShare Participant: _____ **Date:** _____

Signature of Site Representative: _____ **Date:** _____

Site Name: _____ **County:** _____

CENTRAL PENNSYLVANIA FOOD BANK
No One Should Be Hungry
FEEDING AMERICA FEEDING PENNSYLVANIA

CSFP Federal Poverty Income Guidelines Form 202004 – Effective 2/12/20

pennsylvania
DEPARTMENT OF AGRICULTURE
BUREAU OF FOOD DISTRIBUTION

CSFP

HUNGER-FREE PENNSYLVANIA
A Network of Food Banks & Charitable Organizations

Senior Box

2020-21 CSFP Income Guidelines

Elderly - 130%

Household Size	Annual	Monthly	Weekly
1	$16,588	$1,383	$319
2	$22,412	$1,868	$431
3	$28,236	$2,353	$543
4	$34,060	$2,839	$655
5	$39,884	$3,324	$767
6	$45,708	$3,809	$879
7	$51,532	$4,295	$991
8	$57,356	$4,780	$1,103
For each add'l household member, add...	$5,824	$486	$112

*CSFP agencies must implement the adjusted income guidelines for elderly applicants immediately upon receipt.

The Non-Discrimination Statement is on the back. Please turn over.