Request for North Kingstown Food Pantry Food Services HH# _____

I am requesting FOOD for a total of _____ household members. Proof of Residency _____ DATE

My Name Is: Photo ID rec'd _____ DATE

First Name: _____ Last Name: _____

D.O.B. _____ Gender: Male / Female Ethnicity _____
Asian Black Hispanic Native AM White Other

Address: _____, Apt. # _____, N. Kingstown, RI 02852

Home Phone: _____ E-mail: _____

Cell Phone: _____ Photo ID # _____

Housing: RENT OWN HOMELESS OTHER

Total Combined Household Income: $_____ per month

How did you hear about us? ☐ Social Media ☐ TV/Newspaper ☐ Word of Mouth ☐ Other _____

Does anyone in your household have any dietary restrictions? Yes / No (check all that apply)

☐ Gluten Free ☐ Peanut Allergy ☐ Low/No Sugar ☐ Low Salt ☐ Other Allergy_____

***NOTE** – The Pantry will do its best to provide these preferences, but we cannot make any guarantees. Clients should review all items to ensure that there is nothing included that they should not consume due to an allergy or medical condition.

****I have read and understand the above statement.** _____

List All Other Household Members:

Name	Date of Birth	Ethnicity	Male / Female
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F
_____	_____	_____ Asian Black Hispanic Native AM White Other	M F

Certification: I certify that the information provided on this request is true, and I understand that providing false information will disqualify me from this program. I authorize the North Kingstown Food Pantry to give and receive specific information to or from other community service and/or government agencies in order to best serve the needs of my household.

Applicant Signature: _____ Date: _____

Application Taken by: _____ Date: _____

Rev. 4/19/21

The Emergency Food Assistance Program (TEFAP) 2022-2023
Application/Self-Declaration of Eligibility Form
For Use During the Coronavirus Crisis

HH ID# _____

Name: _____

Address:_____

_____

Number of People in Household: _____

Number of Households: _____

You are automatically eligible if you receive any of the following:

- ☐ Child Care Assistance
- ☐ Energy Assistance (LIHEAP)
- ☐ General Public Assistance
- ☐ Refugee Cash Assistance
- ☐ Medicaid
- ☐ RIWorks
- ☐ SNAP (Food Stamps)
- ☐ SSI or SSDI
- ☐ Temporary Disability
- ☐ Unemployment

The table below shows a monthly gross income for each household size at 300% Federal Poverty Level. If your household is at or below the income listed for the number of people in your household, you are eligible to receive TEFAP commodities.

Household Size	1	2	3	4	5	6	7	8	9	10
Monthly Income	$3,398	$4,578	$5,758	$6,938	$8,118	$9,298	$10,478	$11,658	$12,838	$14,018

Please read the following statement carefully, then sign the form and write in today's date:

I certify that my monthly gross household income is at or below the 300% FPL income level listed on this form for households with the same number of people as my household, OR that I am currently enrolled in the program checked off above. I also certify that, as of today, my household lives in the area served by the Rhode Island Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State for the value of the food improperly issued to me and may subject me to criminal prosecution under State and Federal law.

_____ _____
Signature Date

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, 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.