

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	
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		
_____	_____	_____	M	F
		<small>Asian Black Hispanic Native AM White Other</small>		

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: _____

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

Name: _____

Address: _____

Number of People in Household: _____

Number of Households: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Child Care Assistance | <input type="checkbox"/> Medicaid | <input type="checkbox"/> SSI or SSDI |
| <input type="checkbox"/> Energy Assistance (LIHEAP) | <input type="checkbox"/> RIWorks | <input type="checkbox"/> Temporary Disability |
| <input type="checkbox"/> General Public Assistance | <input type="checkbox"/> SNAP (Food Stamps) | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Refugee Cash Assistance | | |

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	\$3,645	\$4,930	\$6,215	\$7,500	\$8,785	\$10,070	\$11,355	\$12,640	\$13,925	\$15,210

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.

Client does not have to sign but may give verbal attestation, that is, say yes, I certify these statements apply to my household; Site Worker should make a record of the household.

Signature

Date

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, 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.

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.

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