

Minnesota: The Emergency Food Assistance Program (TEFAP) Annual Eligibility Form

United States Department of Agriculture (USDA): Community Pathways of Steele County

Name: _____
 Address: _____ City _____ Zip _____
 County: _____ Phone Number _____

For Office Use Only:

Last Name: _____

ID#: _____

I am eligible to receive TEFAP commodity food because I am in Minnesota and because my household income is 300% or less of the Federal Poverty Guidelines. Eligibility is granted to all persons in situations of emergency and distress due to disasters. I am also eligible if I receive or participate in the following services and programs:

OPTIONAL: Check the program(s) in which you participate:

- | | | |
|---|--|---|
| <input type="checkbox"/> MFIP – Minnesota Family Investment Program | <input type="checkbox"/> Child Care Assistance | <input type="checkbox"/> WIC – Women, Infants, and Children |
| <input type="checkbox"/> GA – General Assistance | <input type="checkbox"/> Head Start | <input type="checkbox"/> Energy Assistance |
| <input type="checkbox"/> SNAP – Supplemental Nutritional Assistance Program | <input type="checkbox"/> Section 8 | <input type="checkbox"/> Weatherization |
| <input type="checkbox"/> NAPS – Nutritional Assistance Program for Seniors | <input type="checkbox"/> Public Housing | <input type="checkbox"/> Free and reduced breakfast and lunch |

Income Eligibility: (300% of Federal Poverty Guidelines)

Family size	Annual Income
One	\$0 - \$43,740
Two	\$0 - \$59,160
Three	\$0 - \$74,580
Four	\$0 - \$90,000
Five	\$0 - \$105,420
Six	\$0 - \$120,840
Seven	\$0 - \$136,260
Eight	\$0 - \$151,680

Number of people in household:

Children ages 0-17

Adults ages 18-64

Seniors ages 65+

Add \$5,140 of allowable income for each additional family member.

Proxy Permission for someone else to pick up my food:

If it's hard for you to get food from the food shelf, you have the option to select someone else to pick up your food.

I give permission to: _____ (name) to pick up my food

I understand I have the right to:

- Change who I choose to pick up my food. I may need to fill out a new form for any changes.
- Let the food shelf staff know if I want to cancel my permission.

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 responsible Agency or USDA's TARGET Center at (202)720-2600 (voice and TTY) or 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 complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html or 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: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or fax: (202) 6907442, or email: program.intake@usda.gov. This institution is an equal opportunity provider.

NON-DESCRIMINATION STATEMENT

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. (Not all prohibited bases apply to all programs.). If you feel you have been discriminated against, please ask for our grievance procedure by contacting Community Pathways @ 507-455-2991.

Data Privacy Notice/Tennessee Warning:

You have rights under the Minnesota Government Data Practices Act. This Act protects your privacy. We are asking for information so we can tell you apart from other persons with a similar name and decide how to serve you best.

Generally, you are not required to give us the information; however, without it, we can't report accurate statistics that affect funding. The law allows us to share your information (the number of children, adults, and seniors in your household and the number of pounds of food received) with staff from the Department of Human Services, Hunger Solutions Minnesota, Channel One Food Bank and others who may be authorized to view your information to do their jobs.

You also have the right to copies of information we have about you. If you do not understand the information, it may be explained to you. If you do not think the information is accurate or complete, please correct it with the food shelf staff. I understand that this data privacy notice will expire one (1) year after I have signed it.

Client Signature

Date

COMMUNITY PATHWAYS APPLICATION FOR ASSISTANCE (Optional)

Name (First, Middle Initial, Last)	Date of Birth	*Race	Gender	**Employment Status	Hours per Week	Hourly Wage	Monthly Wage Hours x Wage x 4.3

* Choose From: African American, Asian, Bi-Racial, Caucasian, Hispanic, Latin, Native American, Other, Somali, Sudanese

**Choose From: Disabled, Employed Full-Time, Employed Part-Time, Employed Temp, Homemaker, Laid Off, Medical Leave, Multiple Jobs, Retired, Self-Employed, Student, Unemployed (all children are considered 'Students' regardless of age)

By law, Community Pathways may not discriminate on the basis of this information. **Community Pathways appreciates as much information as possible in order to advocate for our customers.**

Monthly Income for ALL Adults in the household: (Optional)

<u>Monthly Income Source</u>	Amount		Amount
Income / Salary (From above)		Child Support	
Self-Employed Income		County Assistance / MSA	
Social Security (SSI/RSDI)		SNAP (Food Stamps)	
Retirement / Pension / VA		MFIP (MN Family Invest Program)	
Unemployment Compensation		Monthly Total:	
Worker's Compensation			
		Annual Total:	

I agree:

- That all information provided on this application is truthful to the best of my knowledge.
- To inform Community Pathways of any change in my application.
- To only take items needed by my family members listed in this application.
- That I will not sell, barter, or trade items received from Community Pathways and understand that doing so may result in loss of shopping privileges.
- That I will not take items from Community Pathways that are not run through the check-out process and understand that doing so will result in loss of shopping privileges.

Community Pathways reserves the right to limit food at any time. Those who refuse to adhere to limitations may lose their shopping privileges.

Signature of Main Shopper

Date

Optional Messaging Sign Up

TEXT MESSAGING – AUTHORIZATION:

I wish to receive messages from Community Pathways via text message. (Standard text message rates may apply)

Phone # _____

Client Initials _____

Email - Authorization

I give Community Pathways permission to contact me via email for updates and newsletters.

Email Address _____

Client Initials _____

FOR OFFICE USE ONLY:

Application verified by: _____
Initials Date