

PERSON VISITING PANTRY

When did you first access food assistance? (Estimation is ok)

Date: _____

*Last Name: _____ *First Name: _____

Date of Birth: ____/____/____ (mm/dd/yyyy)

Is birth date estimated? Yes No

Gender: Female Male Transgender Undisclosed Other

Marital Status:

Single Married Widow/widower
 Separated Divorced Undisclosed

*Address: _____

Address(Line2): _____ *County: _____

*City: _____ *State: NC *Zip Code: _____

No Fixed Address: Undisclosed

What is your current housing type? (Select one)

- | | |
|---|---|
| <input type="checkbox"/> Emergency Shelter, Mission, Transitional | <input type="checkbox"/> Public Housing |
| <input type="checkbox"/> With Family/Friends | <input type="checkbox"/> Own Home |
| <input type="checkbox"/> Other | <input type="checkbox"/> Undisclosed |
| <input type="checkbox"/> Private Rental | <input type="checkbox"/> Unhoused |

Email Address: _____

*Phone Number: _____

What languages are spoken in your household? (Select all that apply)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mandarin Chinese | <input type="checkbox"/> Undisclosed |
| <input type="checkbox"/> Spanish | |

What is your Ethnicity/Race? (Select all that apply)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> White/ | <input type="checkbox"/> Asian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Alaska Native/Aleut/Eskimo | <input type="checkbox"/> Undisclosed |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Middle-Eastern/North-African | |
| <input type="checkbox"/> American Indian/Native | <input type="checkbox"/> Pacific Islander | |

Do you identify as any of the following? (Select all that apply)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Disability | <input type="checkbox"/> Undisclosed |
| <input type="checkbox"/> Postpartum | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Veteran | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Military service - active duty | <input type="checkbox"/> Evacuee | |

PROFILE

What was your highest education level completed? (Select one)

- | | | |
|--|--|--|
| <input type="checkbox"/> Grades 0-8 | <input type="checkbox"/> Post-Secondary (some) | <input type="checkbox"/> Master's Degree |
| <input type="checkbox"/> Grades 9-11 | <input type="checkbox"/> Trade School / Professional Accreditation | <input type="checkbox"/> PhD |
| <input type="checkbox"/> High School Diploma | <input type="checkbox"/> 2-Year Degree | <input type="checkbox"/> Undisclosed |
| <input type="checkbox"/> GED | <input type="checkbox"/> 4-Year Degree | |

What is your current employment type? (Select one)

- | | | |
|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Post-Secondary Student | <input type="checkbox"/> Retired | <input type="checkbox"/> None |
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Undisclosed | |
| <input type="checkbox"/> Part-Time | <input type="checkbox"/> Other | |

INCOME

What are your sources of income? (Select all sources of income and list monthly amount by each)

- | | | | |
|--|------------|--|----------|
| <input type="checkbox"/> Full-Time Employment | \$ _____ | <input type="checkbox"/> Public Assistance | \$ _____ |
| <input type="checkbox"/> No Income | \$ _____ 0 | <input type="checkbox"/> Social Security Disability (SSDI/SSI) | \$ _____ |
| <input type="checkbox"/> Other | \$ _____ | <input type="checkbox"/> Social Security Retirement | \$ _____ |
| <input type="checkbox"/> Part-Time Employment | \$ _____ | <input type="checkbox"/> Social Security Survivor Benefit | \$ _____ |
| <input type="checkbox"/> Pension (from a past job) | \$ _____ | <input type="checkbox"/> Student Loans | \$ _____ |

Does your household currently receive any of the following? (Select all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Children's Health Insurance Program (CHIP) | <input type="checkbox"/> Section 8 Housing Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Free-or-reduced priced breakfast | <input type="checkbox"/> LIHEAP (Low Income Home Energy Asst) | <input type="checkbox"/> Pension |
| <input type="checkbox"/> Free-or-reduced priced Lunch | <input type="checkbox"/> Medicaid | <input type="checkbox"/> SNAP/FNS/Food Stamps |
| <input type="checkbox"/> Head Start | <input type="checkbox"/> Medicare | <input type="checkbox"/> TANF (Temp Assistance for Needy Families) |
| <input type="checkbox"/> WIC (Supplemental Assistance for women, infants, children) | <input type="checkbox"/> Veterans Aid and Attendance | |

HEALTH AND DIETARY CONSIDERATIONS

Does anyone in your household have any Dietary Considerations? (Select all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Dietary – Dairy | <input type="checkbox"/> Dietary - Pork | <input type="checkbox"/> Dietary – Vegan |
| <input type="checkbox"/> Dietary - Egg | <input type="checkbox"/> Dietary - Red Meat | <input type="checkbox"/> Dietary – Vegetarian |
| <input type="checkbox"/> Dietary - Gluten/Wheat | <input type="checkbox"/> Dietary – Shellfish | <input type="checkbox"/> Health – Diabetic |
| <input type="checkbox"/> Dietary – Kosher | <input type="checkbox"/> Dietary – Sodium | <input type="checkbox"/> Health – Heart Disease |
| <input type="checkbox"/> Dietary – Lactose | <input type="checkbox"/> Dietary – Soy | <input type="checkbox"/> Health - Hypertension |
| <input type="checkbox"/> Dietary – Peanut | <input type="checkbox"/> Dietary - Tree Nuts | <input type="checkbox"/> Other _____ |

SERVICES (COMPLETED BY PANTRY WORKER)

***A TEFAP form is required if client signature is not collected electronically* (store form for 5 yrs.)**

Type of Visit: TEFAP Visit Pantry Visit

Date of Visit: _____ Number of Pounds Served: _____

What are the reasons for this visit?

- | | | |
|---|---|--|
| <input type="checkbox"/> Benefits/Social Assistance Changes | <input type="checkbox"/> Benefit/Social Assistance Delays | <input type="checkbox"/> Debt |
| <input type="checkbox"/> Delayed Wages | <input type="checkbox"/> Disabled | <input type="checkbox"/> Family Breakup |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Low Wages/Not Enough Hours | <input type="checkbox"/> Natural Disaster |
| <input type="checkbox"/> Other | <input type="checkbox"/> Relocation (immigration moving) | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Sickness/Medical Expenses | <input type="checkbox"/> Unemployed/Recently Lost Job | <input type="checkbox"/> Unexpected Expenses |
| <input type="checkbox"/> Unexpected Housing Expenses | | |

Referrals:

- | | | | |
|--------------------------------------|------------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Education | <input type="checkbox"/> Health | <input type="checkbox"/> Housing | <input type="checkbox"/> Income |
| <input type="checkbox"/> None Needed | <input type="checkbox"/> Not Asked | | |

Household Member Info (one sheet for each member)

*Last Name: _____ *First Name: _____

Date of Birth: ____/____/____ (mm/dd/yyyy)

Is birth date estimated? Yes No

Gender: Female Male Transgender Undisclosed

Relationship:

- | | | | |
|--|--------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| <input type="checkbox"/> Grandchild | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other Relative | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Boy/Girl Friend | <input type="checkbox"/> Roommate | | <input type="checkbox"/> Undisclosed |

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| <input type="checkbox"/> WIC (Supplemental Assistance for women, infants, children) | | <input type="checkbox"/> Veterans Aid and Attendance |

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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.

I am applying to be an eligible recipient to receive USDA commodities.

I receive Food and Nutrition Services benefits (Food Stamps). ___ yes ___ no

My household's gross income is \$ _____ monthly.

The number in my household is _____ persons.

Name: _____

Address: _____

City _____ **State** _____

Phone #: _____ **County:** _____

IMPORTANT: READ THIS STATEMENT BEFORE SIGNING FOR FOOD(S).

I understand that any misrepresentation of need, sale, or misuse of the foods I have received is prohibited and could result in a fine, imprisonment, or both. (Sec. 211 E, PL 96-494 and Sec. 4C, PL 93-86 as amended)

Received by: _____
(Signature of Applicant)

Certifying Agency Representative: _____
(signature)

(date)

The following person is authorized to pick up my food:

(Signature of Applicant)

H:agency/orientation/TEFAP/TEFAPclientapplication (Rev. 6/2019)