



Helping People. Changing Lives

PARTNERSHIP

Tri-County Community Action Agency, Inc.

Shelby County Residents

214 Nacogdoches Street • P. O. Drawer 1748

Center, TX 75935

936-598-6315, ext. 501 (office)/936-598-7377 (fax)

HARVEST FOR HOMES FOOD PANTRY APPLICATION

Section 1 – Certification

By signing below, I certify that:

1. I am a member of the household living at the address provided in Section 2 and that, on behalf of the applicant, I apply for food assistance that is distributed by Tri-County Community Action Agency, Inc. (TCCA) purchased with Community Services Block Grant (CSBG) funding;
2. All information provided to TCCA determining this household's eligibility is, to the best of my knowledge and belief, true and correct; and
3. If applicable, the information provided by the household's proxy is, to the best of my knowledge and belief, true and correct.

Signature of household member: _____ Date: _____

Section 2-Applicant Household Information

Applicant's Name: _____
First Middle Last

Applicant's Date of Birth: _____ Gender: ☐ M ☐ F Applicant's Social Security #: _____

Ethnicity: ☐ White ☐ African-American ☐ Native-American ☐ Hispanic ☐ Asian ☐ Other

Address: _____
Street City State Zip

Home Phone: () Cell Phone: ()

Number of household members by age group:

Children (0-17) _____ Adults (18-59) _____ Seniors (60+) _____

Proxy Information: (A proxy is a person/agent legally authorized to act on behalf of the applicant. You can have only ONE proxy per application)

Name of Proxy: _____

Address of Proxy: _____

City / State / Zip: _____

Home Phone #: _____ Cell Phone #: _____

****Please list all other persons living in your household, complete with their name, gender, date of birth, and ethnicity****

(Ethnicity: White=W, African American=AA, Native American=NA, Hispanic=H, Asian=A, Other=O)

Name	Gender	Date of Birth	Social Security #	Ethnicity (Please circle one)
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O
	M F			W AA NA H A O

Section 3-Categorical Eligibility (If eligible under this section, enter the information here and skip to Section 7)

- ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Temporary Assistance for Needy Families (TANF)
☐ Supplemental Security Income (SSI) ☐ Medicaid ☐ Means-Tested Veterans Program

Section 4-Income Eligibility (If eligible under this section, enter the information and skip to Section 7)

Proof of Income:

☐ Employment (Check Stubs) ☐ Unemployment ☐ SSI ☐ SSDI ☐ RSDI ☐ Retirement ☐ Pension ☐ Other_____

Total Gross Income: \$_____ ☐ yearly ☐ monthly ☐ bi-weekly ☐ weekly

Section 5-Health Insurance Information

Does you or any household member have health insurance ☐ Yes ☐ No

If yes, please check the box of every insurance being used in your household: ☐ Medicaid ☐ Medicare ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults ☐ Military Health Care ☐ Direct-Purchase ☐ Employment Based
☐ Marketplace ☐ Unknown

Section-6 Household Crisis/Emergency Food Assistance (to be completed by staff)

If the household is eligible for crisis/emergency food need, document reason here: (Crisis assistance will be provided up to 3 months (NOT 3 TIMES) from the 1st date of assistance; after which, the client must show proof of due diligence to improve his/her living situation)

FOR OFFICE STAFF ONLY

Section 7-Eligibility or Ineligibility (to be completed by staff)

- ☐ Household is eligible Beginning (month/year)_____ Ending (month/year)_____
☐ Household is ineligible based on Section 4.

Staff Signature:_____


Date:_____



FreeSignPhoto.com

****PLEASE READ CAREFULLY BEFORE SIGNING****

RELEASE OF INFORMATION

1. The information provided is true and correct.
2. I understand that my gross household income cannot exceed the 200% federal poverty limit (FPL) for assistance through the Community Services Block Grant Program (CSBG) and is annualized at the time of processing according to pre-established agency rules and procedures in order to receive assistance. However, on October 1, 2021 the FPL will return to 125%.
3. If a client has been determined eligible before October 1, 2021, your eligibility will remain valid up to one year of your initial eligibility determination. After which, you must re-apply for food service assistance.
4. I authorize the Texas Department of Housing and Community Affairs and Tri-County Community Action Agency, Inc. to solicit/verify information including employment verification needed to provide assistance with food service assistance.
5. I am an applicant of Tri-County Community Action Agency, Inc. I hereby give my permission to release and verify all information requested and understand that it will be kept in strict confidence to be used for program purposes only.
6. I understand that a photocopy of this release is as valid as the original and may be used to obtain employment information or verify other data.
7. I understand that if I or another member of the household has no income, a Declaration of Income Statement sheet must be completed for all household members over 18 years of age having no income.
8. I certify that the information provided on this application is true and correct.
9.  I understand that receipt of assistance through misrepresentation, falsification, or fraud is punishable by fine or imprisonment, and **THAT I AM SUBJECT TO PROSECUTION FOR PROVIDING FALSE OR FRAUDULENT INFORMATION ON THIS APPLICATION.**

Household Representative Signature

Date

☐ **Does Not Apply (to be determined by TCCA Staff only)**

1. This form is to be filled ONLY if someone in the household is 18 years of age or older and IS NOT receiving ANY INCOME. The top portion is to be filled out by the Applicant.
2. The middle portion is to be filled out with the name of the person(s) in the household that is 18 years of age or older and IS NOT receiving ANY INCOME.
3. Applicant must state why the person or persons does not have ANY INCOME.
4. Applicant must sign and date form.

DECLARATION OF INCOME STATEMENT (DECLARACION DE INGRESOS)

Applicant Name (Nombre del Solicitante)	Applicant Last Name (Apellido)	Suffix (Sufijo)
Address (Dirección)	City (Ciudad)	Zip Code (Código Postal)

State the gross income for household members, 18 years and older, who have no documentation of the income received in the **30 day period** prior to the date of application for assistance: *(Declarar el ingreso recibido por los miembros de su hogar, que tienen 18 años de edad ó mas, y que no tienen documentación de ingresos por los 30 días antes del aplicar para asistencia)*

Name (Nombre)	Gross Income Received (Ingreso Bruto Recibido)
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My household has no documented proof of income due to the following situation *(Mi hogar no tiene prueba para documentar los ingresos por medio de tal razones)*: _____

I certify that the above information is true and correct to the best of my knowledge and belief. *(Yo certifico que la información proveída de los ingresos es verdadera y correcta según mi saber y creencia.)*

I understand that the information will be verified to the extent possible; and that I may be subject to prosecution for providing false or fraudulent information. *(Comprendo que la información será verificada hasta donde sea posible y que puedo ser enjuiciado por haber proveído información falsa ó fraudulenta.)*

(Applicant Signature/Firma del Solicitante)

(Date/Fecha)