

## San Antonio Food Bank **Partner Agency Pantry Family Intake Form**

Form B

#### (client may fill this out)

Date of Intake:

Are you homeless?  $\Box$  Yes  $\Box$ No If no, please complete address portion of form.

Household Information	l			
YOUR NAME				
ADDRESS				
(if available)				
CITY / STATE/ ZIP/ COUNTY				
PHONE				
Number in				
Household				
GROSS INCOME		Per	Per Month	Per
Amount before deductions $\Psi$		Year		Week
Does your family receive	any type of assistance? cha	eck all that apply	,	
Temporary Assistan	ce To Needy Families (TANF)		SNAP (	(Food Stamps)

#### SSI Medicaid NSLP **Temporary Crisis**

#### Document reason for crisis in "comments" box below.

By signing below, I certify that:

(1) I am a member of the household living at the address provided above and that, on behalf of the household, I apply for USDA Foods that are distributed through The Emergency Food Assistance Program;

(2) all information provided to the agency determining my 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 "Authorized Representative" (as named below) is also, to the best of my knowledge and belief, true and correct.

Client Signature (client must be present for initial interview and food assistance)			
Name of Authorized Representative: (name of person to act on their behalf)	Authorized Representatives Address or Phone:		

**Household is INELIGIBLE:** (Explain the reason for ineligibility in the "comments" box below.) **Comments:** 

#### Household is ELIGIBLE based on:

Low Income		SNAP	
SSI		Medicaid	
NSLP		Temporary Crisis	
	1 5		

Certification period is up to twelve months. For crisis food need certification period is up to six months. Texas Department of Agriculture can approve crisis food need for seven to twelve months. Give length of certification period if household is eligible. Beginning (month/year): \_\_\_\_/\_\_\_ Ending (month/year): \_\_\_\_/\_

#### Agency Staff Signature: \_

Revisit this form on: \_\_\_\_

# Only the information above is required to obtain USDA Foods

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, 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, audicupe, American Sign Language, etc.), should contact the dye use of the effect alter 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 of text contents of USDA programs indegrams of the Assistant Secretary for Civil Rights 1400 Independence Avence. SW Washington, DC. 20250/9410 (2) fax: (202) 609-7442; cr (3) email: <u>program indegrams indegrams of accompany indegrams on the soft accompany.</u> This institution is an equal opportunity provider.

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#### DEMOGRAPHIC INFORMATION (PLEASE REPORT TO SAFB ON MONTHLY REPORTS)

#### How many people live in your house in the following age / gender groups: (please write the number in the box)

0-5 Vrs   0-	18 yrs	19-40 yrs	41-59 yrs		60 and over	
# Males in house			# Females in hous	e		

#### **Military Status:**

Active Military	Retired Military	Reserve	Veteran	
		Military		

#### Please select your race:

American Indian	Asian	Black or African	Native Hawaiian or	White	
or Alaska Native		American	Other Pacific Islander		

#### Please select your ethnicity:

Cuban	Mexican	Puerto Rican	South or Central	Other Spanish culture	
			American	or origin	

#### How many people live in your house in the following groups: (please write the number in the box)

		00 1			
	Physically Disabled	Abuse Victims	Mentally	People with Chronic Illness	
Homeless			Disabled		

### Household Composition:

Two	Senior(s) Raising	Single Parent	Single Adult	Senior Living Alone
Parent	Grandchildren			
Home				

Please have client sign every time they come receive assistance (if you have another form for this that is fine, but you must keep all documentation accessible and together).

Date	Signature of Client (by client)

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