H.O.P.E., Inc

Household Application for Food

Section 1 - Application (To be completed by the household member)
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 household, I am applying for food assistance;
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. The information provided by the household's "Authorized Representative" (as named below or as authorized on a separate page) is also, to the best if my knowledge, true and correct

Printed Name of Household Member

_____

Signature of Household Member

_____

Date

_____

Section 2- Household Information

How many people live in your house? ☐ Are you the head of household? ☐Yes ☐No

Residential Address (if available)

Address	
City/State/Zip	

If the household receives other assistance, mark the appropriate choice(s) below. No proof is required

☐	Supplemental Nutrition Assistance Program (SNAP)
☐	Temporary Assistance for Needy Families (TANF)
☐	Supplemental Security Income (SSI)
☐	National School Lunch Program (NSLP)
☐	Medicaid

What is the Total Gross Income* (the amount before deductions) of all household members?
Optional if household receives other assistance.

Gross Income	☐ Per Year	☐ Per Month	☐ Per Week
	$		

*Farmers and self-employed persons may report NET Income (the amount after business expenses)

Section 3 – Temporary Crisis Food Need
(To be completed by the recipient agency only if the household is determined ineligible on the basis of Section 2 information)

Is the household in need of temporary, crisis food assistance? ☐Yes ☐No

If yes, document the reason for the crisis	

Section 4 - Agency Documentation

☐Household is INELIGIBLE (Please explain in the "comments" box below)

☐Household is ELIGIBLE based on the following (mark the appropriate options)

☐Low Income ☐Medicaid

☐SNAP ☐TANF

☐SSI ☐NSLP (Free or reduced-price meals)

Certification period is up to twelve months. For crisis food need (Section 3), certification period is up to six months
Give length of certification period if household is eligible.
Beginning:_____ Ending: _____

Comments	

Signature of Agency Official _____

Date _____

USDA Nondiscrimination Statement
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, audiotape, 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: 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.

Household Name _____ Phone number _____

Email address _____

List ALL Persons living at this address	M/F	Relationship	Date of Birth	Medical coverage

Household Ethnicity: ___ White/Anglo ___ African American ___ Hispanic/Latino ___ Asian ___ Other

Does anyone in your house receive the following (monthly):

Employment Income $_____ Unemployment $_____

Who _____ Workman's Comp $_____

Employer _____ Child Support $_____

Employment Income $_____ SS $_____

Who _____ VA $_____

Employer _____ Other $_____

(1) I understand that to continue to qualify for assistance I must report any changes in my income or household.
(2) I give permission for H.O.P.E., Inc. to enter this information into Charity Tracker and may be shared with other charitable agencies.
(3) I understand my personal information will be treated confidentially.
(4) I have paid no money, property or services for food or services received.
(5) I acknowledge that H.O.P.E., Inc. neither raises nor processes the food it distributes.
(6) I understand that the products I receive are donated products and are distributed in good faith.
(7) I understand that it is ultimately my responsibility to examine all products before consuming.

Signature _____

Date _____

For office use only

_____ ID _____ Address verification _____