



2011

**EMERGENCY FOOD AND SHELTER PROGRAM  
ELIGIBILITY CERTIFICATION**

2011

**PLEASE PRINT**

1. Applicant name Last, First, MI)		2. Age	3. Gender	4. Race	
5. Address (Street, PO Box, Route #)		6. City	7. Zip Code	8. State <b>Wisconsin</b>	9. County
10. Phone Number	11. Total Monthly Income		12. Income Source (Circle One) SSI / SS / W-2 / Unempl / Empl / None		
13. Marital Status: Single / Married / Divorced / Widowed / Separated (Circle One)					
Total number in household :		# Adults:	# Children:		
Agency, Organization or Person Referred by:					

<b>Determination of Eligibility to Receive</b>										
Instructions: Households larger than 10 people - Add \$6,924 yearly or \$577 monthly for each additional member. Your income may not exceed the federal poverty income guidelines listed for your household size.										
* NOTE: Definition of gross monthly income for self-employed or farmers is gross income minus operating expenses (adjusted gross income).										
<b>a. HOUSEHOLD SIZE:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>b. CURRENT GROSS YEARLY INCOME IS LESS THAN:</b>	\$20,040	\$26,964	\$33,876	\$40,800	\$47,712	\$54,636	\$61,560	\$68,472	\$75,396	\$82,320
<b>c. CURRENT GROSS MONTHLY INCOME IS LESS THAN:</b>	\$1,670	\$2,247	\$2,823	\$3,400	\$3,976	\$4,553	\$5,130	\$5,706	\$6,283	\$6,860

I certify that the above information is true and correct to the best of my knowledge. My signature also certifies that my household income does not exceed the Wisconsin Department of Health and Family Services income limits for participation in this program. Household income includes, but is not limited to, all wages, pensions, Social Security, Supplemental Security Income, Railroad Retirement, income from rented or leased property, interest or dividends from savings, certificates of deposit, stocks, bonds, and income from all other sources.

Client Signature <b>X</b>	Date Signed
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**FOOD PANTRY NAME:**

Rules for participation in the program are the same for everyone without regard to race, color, national origin, ancestry, age, sex, handicap, creed, physical condition, developmental disability, arrest or conviction record, membership in the national guard, state defense force or any reserve component of the military forces of the United States, sexual orientation or marital status.

Client Comments:
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**Racine County Food Bank**  
2000 DeKoven Avenue, Unit #2 • Racine WI 53403-2481  
Phone: 262/632-2307 • Fax: 262/632-2643  
Email: info@racinecountyfoodba

## THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP) ELIGIBILITY CERTIFICATION

Participation in TEFAP is voluntary. Personally identifiable information collected is required for participation and will be used for that purpose only.

**PLEASE PRINT**

Name – Last		First	MI	Telephone Number
Street Address		City	Zip Code	County

**I CERTIFY WITH MY SIGNATURE THAT:**

- My monthly gross household income is at or below the federally approved DPH limits for participation in this program for the number of people in my household as indicated on this form.
- I will use the federal commodities received for household consumption only.
- I release the USDA/FNS, the State of Wisconsin, and any agency or person distributing federal commodities from any liability resulting from receipt of this food.
- I understand that making a false certification may result in my having to reimburse the State for the value of food improperly issued to me and may subject me to criminal prosecution under State and Federal law.
- Rules for acceptance and participation in the program are the same for everyone without regard to race, color, religion, national origin, age, sex or disability.
- Reasonable accommodations may be requested to participate in this program.

**MAXIMUM INCOME FOR RECEIPT OF TEFAP COMMODITIES**

Household Size	Monthly Income	Household Size	Monthly Income	Household Size	Monthly Income
1	\$1,670	4	\$3,400	7	\$5,130
2	\$2,247	5	\$3,976	8	\$5,706
3	\$2,823	6	\$4,553	9	\$6,283
				10	\$6,860

**For each additional household member over ten add \$577 monthly.**

	DATE (MM-DD-YY)	RECIPIENT SIGNATURE	FAMILY SIZE		ADDRESS VERIFIED		DO YOU NEED OTHER ASSISTANCE		TYPE OF OTHER PROGRAM INFORMATION GIVEN TO CLIENT
			ADULTS	CHILDREN	YES	NO	YES	NO	
1.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Name - Pantry	Address - Pantry
Name - Emergency Feeding Organization	Date Form Filled Out (MM-DD-YY)

2011 Love, Inc. CLIENT Intake Form  
Eligibility Certification (1)

SP# \_\_\_\_\_

PRINT Last Name \_\_\_\_\_ PRINT First Name \_\_\_\_\_ PRINT Middle Name \_\_\_\_\_

PRINT Address \_\_\_\_\_ PRINT City/State/Zip \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone : \_\_\_\_\_

Social Security : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Have you had assistance from any other agency in the last 30 days?  Yes  No If yes, Where? \_\_\_\_\_

What is the primary language spoken in home:  English  Spanish  Other \_\_\_\_\_

Gender:  Female  Male  Transgender  Unknown  
Race:  American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino  White  Other Multi-Racial  
Military Veteran:  Yes  No  
Does Veteran have DD Form 214?  Yes  No  
Receiving Veterans Services?  Yes  No

Household:  Caregiver  Foster Parent(s)  Married  Couple w/Dependent Children  Couple (Non-Married) and Children  Single  Couple w/No Children  Non-Custodial Caregiver(s)  Other  Single w/Dependent children  Grandparent(s) and Children

Marital Status:  Married  Separated  Divorced  Widowed  Single  
Juvenile Parent:  Yes  No

# of People in Household: \_\_\_\_\_ # of Children in Household: \_\_\_\_\_ # of Children NOT in Household: \_\_\_\_\_

Women: Pregnant?  Yes  No If Yes, Projected Birth Date: \_\_\_\_\_  
Prenatal Medical Care?  Yes  No

(Please list additional information on spouse and/or children on following pages)

Living Situation:  Rent House / Apartment / Room  Rooming House  Domestic Violence Situation  
 Own House / Apartment  Emergency Shelter  Place not Meant for Habitation  
 Living with Family  Permanent Housing for Formerly Homeless  Homeless  
 Living with Friends

Name of Landlord or Mortgage Company: \_\_\_\_\_

Date of Occupancy: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

Length of Stay:  1 week or less  More than 1 week, but less than 1 month  1 to 3 months  More than 3 months, but less than 1 year  
 1 year or longer

If less than 6 months, previous living situation/address:

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

First Time Homeless:  Yes  No When did Present Homelessness begin? \_\_\_\_\_

Primary Reason for Homelessness:  Addiction  Eviction  Lifestyle Preference  
 Can't find affordable housing  Family/Domestic Violence  Low or No Income  
 Denied/Delayed/Term Public Assistance  Family/Personal Illness/Injury  Discharge (Hospital/Detox)  
 Disaster (fire, flood, etc.)  In Transit  Other \_\_\_\_\_  
 Jail, Prison or Juvenile Facility  
On Probation:  Yes  No  
On Parole:  Yes  No



**2011 Love, Inc. CLIENT Intake Form  
HOUSEHOLD MEMBER 2**

SP# \_\_\_\_\_

(Only record the information for people staying in the household)

PRINT Last Name \_\_\_\_\_ PRINT First Name \_\_\_\_\_ PRINT Middle Name \_\_\_\_\_

Social Security : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

- Gender:**  Female  Male  Transgender  Unknown
- Race:**  American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino  White  Other Multi-Racial
- Military Veteran:**  Yes  No  
Does Veteran have DD Form 214?  Yes  No  
Receiving Veterans Services?  Yes  No

**Relationship to Client:**  Spouse  Daughter  Son  Other \_\_\_\_\_

- Current Employment Status:**  
 Full-time  Part-time  Retired  Self-Employed  Student  Unemployed-Seeking Work  
 Unemployed-Not Seeking Work / Not Job Ready or Employable (Please explain)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Current Employment Type:  Permanent  Temporary  Seasonal

Hours Per Week: \_\_\_\_\_ Take Home Pay: \_\_\_\_\_ Pay Per Hour: \_\_\_\_\_ Paid:  Weekly  Bi-Weekly  Monthly

Means of Transportation: \_\_\_\_\_ Valid Drivers License?  Yes  No

- Level of Education:**  
 Elementary School  Certification  
 Some High School (Grade Level Completed) \_\_\_\_\_  Some College  
 High School/GED  College Degree (  2/Year  4/Year)

**If Student, Name of School / Grade/ Date of Completion / Course of Study:**  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a disability of long duration?**  Yes  No

- If yes, what type of disability?**  
 Alcohol Abuse  Developmental Disabilities  Dual Diagnosis  HIV/AIDS/Hepatitis/TB  
 Drug Abuse  Physical/Medical  Vision Impaired  Hearing Impaired  
 Mental Illness  Physical/Mobility Limits  Other \_\_\_\_\_

**Do you receive SSI / SSD for this disability?**  Yes  No

**OFFICE USE ONLY:**  
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**2011 Love, Inc. CLIENT Intake Form  
HOUSEHOLD MEMBER 3**

SP# \_\_\_\_\_

(Only record the information for people staying in the household)

PRINT Last Name \_\_\_\_\_ PRINT First Name \_\_\_\_\_ PRINT Middle Name \_\_\_\_\_

Social Security : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

**Gender:**  Female  Male  Transgender  Unknown  
**Race:**  American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino  White  Other Multi-Racial  
**Military Veteran:**  Yes  No  
Does Veteran have DD Form 214?  Yes  No  
Receiving Veterans Services?  Yes  No

**Relationship to Client:**  Spouse  Daughter  Son  Other \_\_\_\_\_

**Current Employment Status:**  
 Full-time  Part-time  Retired  Self-Employed  Student  Unemployed-Seeking Work  
 Unemployed-Not Seeking Work / Not Job Ready or Employable (Please explain)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Current Employment Type:  Permanent  Temporary  Seasonal

Hours Per Week: \_\_\_\_\_ Take Home Pay: \_\_\_\_\_ Pay Per Hour: \_\_\_\_\_ Paid:  Weekly  Bi-Weekly  Monthly

Means of Transportation: \_\_\_\_\_ Valid Drivers License?  Yes  No

**Level of Education:**  
 Elementary School  Certification  
 Some High School (Grade Level Completed) \_\_\_\_\_  Some College  
 High School/GED  College Degree ( 2/Year  4/Year)

**If Student, Name of School / Grade/ Date of Completion / Course of Study:**  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a disability of long duration?**  Yes  No

**If yes, what type of disability?**  
 Alcohol Abuse  Developmental Disabilities  Dual Diagnosis  HIV/AIDS/Hepatitis/TB  
 Drug Abuse  Physical/Medical  Vision Impaired  Hearing Impaired  
 Mental Illness  Physical/Mobility Limits  Other \_\_\_\_\_

**Do you receive SSI / SSD for this disability?**  Yes  No

**OFFICE USE ONLY:**  
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**2011 Love, Inc. CLIENT Intake Form  
HOUSEHOLD MEMBER 5**

SP# \_\_\_\_\_

(Only record the information for people staying in the household)

PRINT Last Name \_\_\_\_\_ PRINT First Name \_\_\_\_\_ PRINT Middle Name \_\_\_\_\_

Social Security : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

**Gender:**  Female  Male  Transgender  Unknown  
**Race:**  American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino  White  Other Multi-Racial  
**Military Veteran:**  Yes  No  
Does Veteran have DD Form 214?  Yes  No  
Receiving Veterans Services?  Yes  No

**Relationship to Client:**  Spouse  Daughter  Son  Other \_\_\_\_\_

**Current Employment Status:**  
 Full-time  Part-time  Retired  Self-Employed  Student  Unemployed-Seeking Work  
 Unemployed-Not Seeking Work / Not Job Ready or Employable (Please explain)  
\_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Length of Employment:** \_\_\_\_\_ **Current Employment Type:**  Permanent  Temporary  Seasonal

**Hours Per Week:** \_\_\_\_\_ **Take Home Pay:** \_\_\_\_\_ **Pay Per Hour:** \_\_\_\_\_ **Paid:**  Weekly  Bi-Weekly  Monthly

**Means of Transportation:** \_\_\_\_\_ **Valid Drivers License?**  Yes  No

**Level of Education:**  
 Elementary School  Certification  
 Some High School (Grade Level Completed) \_\_\_\_\_  Some College  
 High School/GED  College Degree (  2/Year  4/Year)

**If Student, Name of School / Grade/ Date of Completion / Course of Study:**  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a disability of long duration?**  Yes  No

**If yes, what type of disability?**  
 Alcohol Abuse  Developmental Disabilities  Dual Diagnosis  HIV/AIDS/Hepatitis/TB  
 Drug Abuse  Physical/Medical  Vision Impaired  Hearing Impaired  
 Mental Illness  Physical/Mobility Limits  Other \_\_\_\_\_

**Do you receive SSI / SSD for this disability?**  Yes  No

**OFFICE USE ONLY:**  
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**2011 Love, Inc. CLIENT Intake Form  
HOUSEHOLD MEMBER 7**

SP# \_\_\_\_\_

(Only record the information for people staying in the household)

PRINT Last Name \_\_\_\_\_ PRINT First Name \_\_\_\_\_ PRINT Middle Name \_\_\_\_\_

Social Security : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

**Gender:**  Female  Male  Transgender  Unknown  
**Race:**  American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino  White  Other Multi-Racial  
**Military Veteran:**  Yes  No  
Does Veteran have DD Form 214?  Yes  No  
Receiving Veterans Services?  Yes  No

**Relationship to Client:**  Spouse  Daughter  Son  Other \_\_\_\_\_

**Current Employment Status:**  
 Full-time  Part-time  Retired  Self-Employed  Student  Unemployed-Seeking Work  
 Unemployed-Not Seeking Work / Not Job Ready or Employable (Please explain)  
\_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Length of Employment:** \_\_\_\_\_ **Current Employment Type:**  Permanent  Temporary  Seasonal

**Hours Per Week:** \_\_\_\_\_ **Take Home Pay:** \_\_\_\_\_ **Pay Per Hour:** \_\_\_\_\_ **Paid:**  Weekly  Bi-Weekly  Monthly

**Means of Transportation:** \_\_\_\_\_ **Valid Drivers License?**  Yes  No

**Level of Education:**  
 Elementary School  Certification  
 Some High School (Grade Level Completed) \_\_\_\_\_  Some College  
 High School/GED  College Degree (  2/Year  4/Year)

**If Student, Name of School / Grade/ Date of Completion / Course of Study:**  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a disability of long duration?**  Yes  No

**If yes, what type of disability?**  
 Alcohol Abuse  Developmental Disabilities  Dual Diagnosis  HIV/AIDS/Hepatitis/TB  
 Drug Abuse  Physical/Medical  Vision Impaired  Hearing Impaired  
 Mental Illness  Physical/Mobility Limits  Other \_\_\_\_\_

**Do you receive SSI / SSD for this disability?**  Yes  No

**OFFICE USE ONLY:**  
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**2011 Love, Inc. CLIENT Intake Form**  
Intake Verification Items

SP# \_\_\_\_\_

Verification Date	Verified By	Items Required for Food Pantry Eligibility
		<b>PICTURE ID (For Head of Household)</b> <input type="checkbox"/> Valid Drivers <input type="checkbox"/> License State ID Card <input type="checkbox"/> Human Services <input type="checkbox"/> Work ID <input type="checkbox"/> Other _____
		<b>VERIFICATION OF HOUSEHOLD SIZE (For Each Member Of The Household)</b> <input type="checkbox"/> Medical Card <input type="checkbox"/> Immunization Record <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Social Security Card <input type="checkbox"/> Other _____
		<b>INCOME VERIFICATION (For Each Member of the Household with any Income, Include Information covering the Last Month)</b> <input type="checkbox"/> Check Stub <input type="checkbox"/> Statement Letter <input type="checkbox"/> Other _____
		<b>PROOF OF CURRENT ADDRESS</b> <input type="checkbox"/> Utility Bill <input type="checkbox"/> Phone Bill <input type="checkbox"/> Rent Receipt <input type="checkbox"/> Lease Agreement <input type="checkbox"/> Other _____

**ALL THE ABOVE ITEMS MUST BE VERIFIED**  
**WITHIN THREE VISITS**

**FAILURE**  
to Comply with  
**VERIFICATION REGULATIONS**  
May Result in Losing Your  
**PRIVILEGE TO PARTICIPATE**  
in the  
**FOOD PANTRY**  
and Any or All  
**ASSOCIATED PROGRAMS at LOVE, INC.**