



**Indiana State Department of Health
The Emergency Food Assistance Program (TEFAP)
Effective April 01, 2017**

PLEASE PRINT

Name: _____

Address: _____

Zip Code: _____ Number in Household: _____

GRAY AREA OPTIONAL: 0-5 _____ # 6-17 _____ # 18-54 _____ # 55-64 _____ # 65+ _____ # veterans _____

I HEREBY CERTIFY THAT MY HOUSEHOLD INCOME IS AT OR BELOW THE FOLLOWING GUIDELINES:

| INCOME GUIDELINES (185%) | | | | | |
|--------------------------|------------------|----------|----------------|------------------|----------|
| HOUSEHOLD SIZE | HOUSEHOLD INCOME | | HOUSEHOLD SIZE | HOUSEHOLD INCOME | |
| | (Monthly) | (Annual) | | (Monthly) | (Annual) |
| 1 | \$1,860 | \$22,311 | 4 | \$3,793 | \$45,510 |
| 2 | \$2,504 | \$30,044 | 5 | \$4,437 | \$53,243 |
| 3 | \$3,149 | \$37,777 | 6 | \$5,082 | \$60,976 |

For each additional household member add \$645.00 per month

I ACKNOWLEDGE THAT THE STATE OF INDIANA AND THIS DISTRIBUTION AGENCY HAVE NO CONTROL OVER THE MANUFACTURING OF THIS DONATED PRODUCT AND CONSEQUENTLY DO NOT WARRANT THE CONDITION, QUALITY, OR CONTENT OF THE USDA DONATED COMMODITY.

| Date | Signature | Date | Signature |
|------|-----------|------|-----------|
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