The Emergency Food Assistance Program (TEFAP)
Proxy Statement Form- Effective July 1, 2024

PANTRY: _____ **COUNTY:** _____

ADDRESS: _____

Recipient provides the information below, confirms review of current income guidelines, and attests to household income or categorical eligibility.

Categorical eligibility:

Women, Infants, and Children (**WIC**) _____	Supplemental Nutrition Assistance Program (**SNAP**) _____	National School Lunch Program (**NSLP**) _____

OPTIONAL AND NOT REQUIRED TO RECEIVE FOOD

Age ranges: _____ # 0-5 _____ #6-17 _____#18-54 _____#55-59 _____#60-64 _____#65+ _____# Veteran

Race: ___ White ___Black ___Asian ___American Indiana/Alaskan Native ___Native Hawaiian / Pacific Islander

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino

Employed? ____ Yes ____ No

RECIPIENT INFORMATION

PHONE NUMBER	( ) -	
NAME		HOUSEHOLD SIZE
ADDRESS	CITY	ZIP

PROXY INFORMATION

NAME		
ADDRESS	CITY	ZIP

Proxy designation is
___ Temporary
___ Permanent

Site personnel completing form _____

Date _____

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