

YOUR AGENCY'S NAME HERE

**EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)
CERTIFICATION OF ELIGIBILITY TO TAKE FOOD HOME**

7 CFR 251

Name: _____

Number of People In Household: _____

Address: _____

County _____

The following shows a yearly gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive food. **The chart below is effective July 1, 2018 - June 30, 2019.**

Household Size	Annual Income	Monthly Income	Twice per Month	Every two Weeks	Weekly Income
1	\$15,782	\$1,316	\$658	\$607	\$304
2	\$21,398	\$1,784	\$892	\$823	\$412
3	\$27,014	\$2,252	\$1,126	\$1,039	\$520
4	\$32,630	\$2,720	\$1,360	\$1,255	\$628
5	\$38,246	\$3,188	\$1,594	\$1,471	\$736
6	\$43,862	\$3,656	\$1,828	\$1,687	\$844
7	\$49,478	\$4,124	\$2,062	\$1,903	\$952
8	\$55,094	\$4,592	\$2,296	\$2,119	\$1,060
For each additional family member add:	\$5,616	\$468	\$234	\$216	\$108

The chart details eligibility criteria for monthly income, income received twice monthly (24 payments per year), income received every two weeks (26 payments per year) and weekly income.

You are eligible to receive food from TEFAP if your household meets the income guidelines above or participates in any of the following programs. Please place a checkmark in the space next to the category that applies.

- _____ Income eligibility
- _____ Supplemental Nutrition Assistance Program (SNAP) (fka Food Stamps)
- _____ Temporary Assistance to Needy Families (TANF)
- _____ Supplemental Security Income (SSI)
- _____ Medicaid

Please read the following statement carefully and then sign the form and write in today's date. You only need to meet one of these requirements to be eligible to receive USDA foods.

*I certify that my yearly household gross income is at or below the income listed on this form for households with the same number of people **OR** that I participate in the program(s) that I have checked on this form. I also certify that as of today, I reside in the State of Florida. This certification is being submitted in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State agency for the value of the food improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.*

Signature

Date

THIS CERTIFICATION IS VALID FOR A PERIOD OF ONE YEAR and may be renewed as needed. Any changes in the household's circumstances must be reported to the distributing agency immediately.

OPTIONAL: I authorize _____ to pick up USDA foods on my behalf.

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.

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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.

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