STATE OF DELAWARE
FEDERAL FOOD COMMODITIES PROGRAM
ELIGIBILITY TO TAKE FOOD HOME

TEFAP Agency_____

Revised 6/20/17

Name: _____ Number of People in Household: _____

Address: _____

This table shows an annual 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

Household Size	Annual Income	Monthly Income	Weekly Income
1	22,311	1,860	430
2	30.044	2,504	578
3	37,777	3,149	727
4	45,510	3,793	876
5	53.243	4,437	1,024
6	60,976	5,082	1,173
7	68,709	5,726	1,322
8	76,442	6,371	1,471
For each additional family member add:	+7,733	+645	+149

( ) Income is less than listed on above income scale.

You are also eligible to receive food from TEFAP if your household participates in any of the following programs. If you participate in one of these programs, please place a check next to the program.

_____ SNAP (FOOD STAMPS) _____ Medicaid _____ GA _____ SSDI

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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.

Please read the following statement carefully. Then sign the form and write in today's date.

I certify that my annual gross income is at or below the income listed on this form for households with the same number of people as my household, OR that my household participates in the program that I have checked on this form. I also certify that, as of today, my household lives in the area served by the Delaware Emergency Food Assistance Program. This certification form is being completed 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 for the value of the food improperly issued to me and may subject me to criminal prosecution under State and Federal law.

_____ _____
(Signature) (Date)

_____ _____
(Proxy Signature) (Date)

Proxy Address
_____
_____
_____