

CROTON CORTLANDT FOOD PANTRY INTAKE REGISTRATION

MAIN CONTACT/HEAD OF HOUSEHOLD (Your) INFORMATION – Please Print Clearly

MAIN CONTACT	FIRST NAME	LAST NAME	DATE OF BIRTH	GENDER
			-- / -- / ---- (mm/dd/yyyy)	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
	ADDRESS & CONTACT INFO			
	Street Address:		Zip Code:	
	Cell # : (--) -- - --		Other # : (--) -- - --	

OTHER	LANGUAGES SPOKEN AT HOME		
	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other (specify): _____
	ETHNICITY		
	<input type="checkbox"/> Alaska Native / Aleut / Eskimo <input type="checkbox"/> American Indian / Native American <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American	<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Middle-Eastern / North African <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White / Anglo	<input type="checkbox"/> Biracial/Multi-racial <input type="checkbox"/> Other

OTHER HOUSEHOLD MEMBERS:

FIRST NAME	LAST NAME	DATE OF BIRTH OR	AGE	GENDER
		-- / -- / ---- (mm/dd/yyyy)		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
		-- / -- / ---- (mm/dd/yyyy)		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
		-- / -- / ---- (mm/dd/yyyy)		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
		-- / -- / ---- (mm/dd/yyyy)		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
		-- / -- / ---- (mm/dd/yyyy)		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other

Office Use Only:	<input type="checkbox"/> New <input type="checkbox"/> Renewal	Card #:	Date:
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The Emergency Food Assistance Program (TEFAP) Attestation of Eligibility

Recipient Name:			
Zip Code:		Total Household Members:	

Step 1: Check one of the two boxes below to indicate how you are eligible for TEFAP.

- ☐ **Categorical:** You are categorically eligible to receive USDA Foods through TEFAP if your household participates in any of the following programs: **SNAP, WIC, TANF, Medicaid, or SSI.**
- OR -
- ☐ **Household Income:** If your gross annual household income is at or below 225% of the federal poverty level for the number of people in your household, you are eligible to receive USDA Foods through TEFAP (see appendix A).

Step 2: Check the box below to attest, then sign and date.

- ☐ **By checking here, you attest that the following is true:**
1. The recipient's name, zip code and household size provided above is correct.
 2. The recipient resides within New York State (there is no minimum length of residency required).
 3. The recipient meets the TEFAP eligibility guidelines in step 1.
 4. This food is for the recipient's home consumption only, and will not be sold, traded, or bartered.
 5. The recipient is aware of their civil rights as described in the USDA Nondiscrimination Statement below.

Signature (Optional)

Date (Required)

This form should remain on site where food is received.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed [AD-3027](#) form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.