

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 <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent	Site personnel completing form _____ Date _____
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