FARM SHARE, Inc.

THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)
CERTIFICATION OF ELIGIBILITY TO TAKE FOOD HOME
7 CFR 251

INFORMATION IN BOLD IS MANDATORY.

Name: _____ **Number of People in Household: _____**

County: _____ **Zip Code:_____**

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. TEFAP Income Eligibility Guidelines - 2025

Household Size	Annual Income	Monthly Income	Twice per Month	Every two Weeks	Weekly Income
1	$46,950	$3,913	$1,956	$1,806	$903
2	$63,450	$5,288	$2,644	$2,440	$1,220
3	$79,950	$6,663	$3,331	$3,075	$1,538
4	$96,450	$8,038	$4,019	$3,710	$1,855
5	$112,950	$9,413	$4,706	$4,344	$2,172
6	$129,450	$10,788	$5,394	$4,979	$2,489
7	$145.950	$12,163	$6,081	$5,613	$2,807
8	$162,450	$13,538	$6,769	$6,248	$3,124
For each additional family member add:	$16,500	$1,375	$688	$635	$317

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) (aka Food Stamps)
_____Temporary Assistance to Needy Families (TANF)
_____Supplemental Security Income (SSI)
_____Medicaid

☐ **The Local Distributing Agency staff must check this box, after the applicant has read the below certification statement:**

I certify, by self attesting, 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. 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.

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

Any changes in the household's circumstances must be reported to the distributing agency immediately.

PLEASE REFER TO THE REVERSE SIDE OF THIS DOCUMENT FOR ADDITIONAL INFORMATION AND THE USDA NON-DISCRIMINATION STATEMENT. ADDITIONAL INFORMATION IS NOT PART OF TEFAP AND IS NOT ENDORSED BY USDA AND THE FLORIDA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES. PROVIDING ADDITIONAL INFORMATION IS NOT A CONDITION TO RECEIVE USDA FOODS.

"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, 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, audiotape, 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.

THE QUESTIONS BELOW ARE OPTIONAL:

Please indicate the age group of the members of your household:
Infant (0-4 mo.): _____ Toddler (5 mo.-3 yr.): _____ Child (3-12.5 yr.): _____
Teen: (12-17 yr.): _____ Adult (18-54.5r.): _____ Senior (55+ yr.): _____

Is the recipient or anyone in the household a veteran or an active member of the armed forces:
Yes: _____ No: _____ Active Duty: _____

Are you currently employed? Yes: _____ No: _____
Part Time: _____ Full Time: _____ Temporary: _____ Disabled: _____

Do you own, rent or live with relatives?
Own: _____ Rent: _____ Live with relatives: _____ Other: _____

What is your level of education:
Some High School: _____ High School/GED: _____ Some College: _____ Vocational: _____
Associates: _____ Masters: _____ Doctorate: _____