

**The Emergency Food Assistance Program (TEFAP)
Proxy Statement Form- Effective January 6, 2025**

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

NAME		HOUSEHOLD SIZE
CITY	COUNTY	ZIP

PROXY INFORMATION

NAME		
CITY	COUNTY	ZIP

Proxy designation is
Temporary
Permanent

Site personnel completing form _____

Date _____

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