**PAPER INTAKE FORM – PLEASE PRINT CLEARLY**

Please answer all questions so that we may serve you better. Your personally identifying information *will not be shared* with any other outside agency or entity other than the Good Shepherd Food Bank and its partner agencies. This information will not prevent you from receiving service.

🞏 I understand Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

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| ABOUT YOU | |
| \* Last Name: \* First Name:  \* Date of Birth: / / (mm/dd/yyyy) Is this an estimated birthdate?  YES | |
| \* **Gender:**   Male  Female  Transgender  Non-Binary/Third Gender/Other  Prefer Not to Say | |
| \* Address: Address (Line 2):  \* City: \* County: \* State: \* Zip Code: \_\_\_\_\_\_\_\_\_\_\_   No Fixed Address | |
| \* **Housing Type:**   * Emergency Shelter/Mission/Transitional * Evacuee * Other * Own Home * Private Rental * Public (Social) Housing | * Prefer Not to Say * Unhoused * With Family/Friends * Youth Home/Shelter * Section 8 (Voucher) Housing * Senior Subsidized Housing |
| **Email Address(es):** **🞏** Personal **🞏** Work **🞏** Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone Number(s):** Please select one (1) as your *primary* phone number  **🞏** Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏** Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏** Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Language(s) Spoken:**  🞏 English 🞏 Somali 🞏 Spanish 🞏 Other (Please Specify):  🞏 Arabic 🞏 Portuguese 🞏 French \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| ABOUT YOU - Continued | | |
| \* **How did you learn about us:**   * Benefits/Social Service Assistance * Child Care Support * Client/Friend/Family * Community Support Organization * Emergency Shelter * Employment Support/Education * Faith – Based Organization * Financial Support/Education * Health Care Organization * Housing Support | * Immigration Services * Legal Support * Media/News/Outreach * Mental health Support/Education * Nutrition Education * Other Food Bank/Pantry * School Program * Social Worker * Utilities Support * None * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \* **Ethnicity:**   * White/Anglo * Black/African American * Hispanic/Latino(a) * American Indian/Native American * Asian | * Alaska Native/Aleut/Eskimo * Middle-Eastern/North-African * Pacific Islander * None * Other * Prefer Not to Say | |
| \* **Do You Self – Identify As:**   * Breastfeeding * Evacuee * History of Homelessness * Postpartum * Pregnant | * Refugee * Disability * Veteran * Other * None * Prefer Not to Say | |
| \* **Highest Level of Education Completed:**  🞏 Grades 0-8 🞏 Grades 9-11 🞏 High School Diploma 🞏 GED 🞏 Post-Secondary (some)  🞏 Trade-school/Professional Accreditation 🞏 2-Year Degree 🞏 4-Year Degree  🞏 Master’s Degree 🞏 PhD 🞏 Prefer Not to Say | | |
| \* **Employment Type:**  🞏 Not Currently Employed, but Seeking 🞏 Not Currently Employed 🞏 Post-Secondary Student  🞏 Full-Time 🞏 Part-Time 🞏 None 🞏 Prefer Not to Say 🞏 Other 🞏 Retired | | |
| If you have additional members in your household, please include their information on Page 3. If you do not have additional members in your household, please proceed to Page 4. | | |
| \*\*YOUR HOUSEHOLD MEMBERS\*\*  *(Do not include yourself)*  If you have more than TWO (2) additional members in your household, please let a staff member know. | | |
| **\* Last Name: \* First Name**:  **\* Date of Birth:** / / (mm/dd/yyyy) Is this an estimated birthdate? 🞏 YES  \* **Gender:**  🞏 Male 🞏 Female 🞏 Transgendered 🞏 Non Binary/Third Gender/Other 🞏 Prefer Not to Say  **\* Relationship to Me:**  🞏 Spouse 🞏 Child 🞏 Parent 🞏 Sibling 🞏 Grandchild 🞏 Grandparent 🞏 Other Relative  🞏 Boyfriend/Girlfriend 🞏 Friend 🞏 Roommate 🞏 Prefer Not to Say 🞏 Ward 🞏 Other  \* **Ethnicity:**  🞏 White/Anglo 🞏 Black/African 🞏 Hispanic/Latino(a) 🞏 American Indian/Native American 🞏 Asian  🞏 Alaska Native/Aleut/Eskimo 🞏 Middle-Eastern/North-African 🞏 Pacific Islander  🞏 Prefer Not to Say 🞏 Other 🞏 None  \* **Do Any of the Following Apply to This Person:**  🞏 Breastfeeding 🞏 Evacuee 🞏 History of Homelessness 🞏 Postpartum 🞏 Pregnant  🞏 Refugee 🞏 Disability 🞏 Veteran 🞏 Other 🞏 None 🞏 Prefer Not to Say | | |
| **\* Last Name: \* First Name:**  **\* Date of Birth:** / / (mm/dd/yyyy) Is this an estimated birthdate? 🞏 YES  \* **Gender:**  🞏 Male 🞏 Female 🞏 Transgendered 🞏 Non Binary/Third Gender/Other 🞏 Prefer Not to Say  **\* Relationship to Me:**  🞏 Spouse 🞏 Child 🞏 Parent 🞏 Sibling 🞏 Grandchild 🞏 Grandparent 🞏 Other Relative  🞏 Boyfriend/Girlfriend 🞏 Friend 🞏 Roommate 🞏 Prefer Not to Say 🞏 Ward 🞏 Other  \* **Ethnicity:**  🞏 White/Anglo 🞏 Black/African 🞏 Hispanic/Latino(a) 🞏 American Indian/Native American 🞏 Asian  🞏 Alaska Native/Aleut/Eskimo 🞏 Middle-Eastern/North-African 🞏 Pacific Islander  🞏 Prefer Not to Say 🞏 Other 🞏 None  \* **Do Any of the Following Apply to This Person:**  🞏 Breastfeeding 🞏 Evacuee 🞏 History of Homelessness 🞏 Postpartum 🞏 Pregnant  🞏 Refugee 🞏 Disability 🞏 Veteran 🞏 Other 🞏 None 🞏 Prefer Not to Say | | |
| *YOUR* MONTHLY INCOME | |
| \* **Your Monthly Income Sources and Amounts:**  *Include as many income amounts as needed.*  *Please* ***select******one(1)*** *as your* ***primary*** *income source.*  **🡫**   * $\_\_\_\_\_\_\_\_\_\_\_\_ Full – Time Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Part – Time Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Temporary/Seasonal Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Pension * $\_\_\_\_\_\_\_\_\_\_\_\_ Disability * $\_\_\_\_\_\_\_\_\_\_\_\_ Supplemental Security Income (SSI) * $\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Disability Income(SSDI) * $\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Benefits * $\_\_\_\_\_\_\_\_\_\_\_\_ Volunteer * $\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * No Income * Prefer not to Say | **Your Social Services Received:**   * Elderly Low Cost Drug Program * Elderly Tax and Rent Refund * General Assistance * LIHEAP * Medicaid/Mainecare * Medicare * School Meals * SNAP - formerly food stamps * SSDI * SSI * TANF * Supplemental Assistance for Women, Infants and Children (WIC) * Vets Aid * Other * None |
| HOUSEHOLD MEMBER INCOME  If you have more than ONE (1) additional household member, please let a staff member know. | |
| **Household Member Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Monthly Income Sources and Amounts:**  *Enter as many income amounts as needed.*  *Please* ***select******one(1)*** *as their* ***primary*** *income source.*  **🡫**   * $\_\_\_\_\_\_\_\_\_\_\_\_ Full – Time Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Part – Time Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Temporary/Seasonal Employment * $\_\_\_\_\_\_\_\_\_\_\_\_ Pension * $\_\_\_\_\_\_\_\_\_\_\_\_ Disability * $\_\_\_\_\_\_\_\_\_\_\_\_ Supplemental Security Income (SSI) * $\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Disability Income(SSDI) * $\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Benefits * $\_\_\_\_\_\_\_\_\_\_\_\_ Volunteer * $\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * No Income * Prefer not to Say | **Social Services Received:**   * Elderly Low Cost Drug Program * Elderly Tax and Rent Refund * General Assistance * LIHEAP * Medicaid/Mainecare * Medicare * School Meals * SNAP - formerly food stamps * SSDI * SSI * TANF * Supplemental Assistance for Women, Infants and Children (WIC) * Vets Aid * Other * None |
| DIETARY CONSIDERATIONS | |
| **Should We Be Aware of Any of the Following:**  🞏 Diabetic 🞏 Egg 🞏 Fruit 🞏 Gluten 🞏 Milk 🞏 Sesame 🞏 Soy  🞏 MSG 🞏 Peanut 🞏 Pork 🞏 Seafood 🞏 Sulphite 🞏 Tree Nuts  🞏 Vegan 🞏 Vegetarian 🞏 Wheat 🞏 Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| NOTES  *Please include any information you would like us to know so that we may serve you better, such as detailing dietary considerations and allergies or requesting specific products.*  *Example: “We are looking for diapers” or "Our child needs gluten-free snacks for school."* | |
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| TEFAP CERTIFICATION |
| **Disclaimer**  This table shows a yearly 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.  **State of Maine TEFAP Income Guidelines**  **July 1, 2021 to June 30, 2022**  **185% of Maine Poverty Guidelines**   |  |  |  |  | | --- | --- | --- | --- | | Household Size | Annual | Month | Week | | 1 | **$23,828** | **$1,986** | **$458** | | 2 | **$32,227** | **$2,686** | **$620** | | 3 | **$40,626** | **$3,386** | **$781** | | 4 | **$49,025** | **$4,085** | **$943** | | 5 | **$57,424** | **$4,785** | **$1,104** | | 6 | **$65,823** | **$5,485** | **$1,266** | | 7 | **$74,222** | **$6,185** | **$1,427** | | 8 | **$82,621** | **$6,885** | **$1,586** | | For Each Additional Add | **+$8,399** | **+$700** | **+$162** |   You also may be eligible to receive food from TEFAP if your income is greater than that shown in the above table providing you are unable to meet the nutritional needs of your household due to an emergency situation.  Please read the following statement carefully and then sign the form with today’s date.  I certify that my annual household 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 the household’s nutritional needs are not being met due to an emergency situation or that I have established eligibility in one of the following: a)LIHEAP; b)TANF; c)SSI, d)Medicaid; e) Elderly Low Cost Drug Program; f) Elderly Tax and Rent Refund; or g) SNAP(formerly food stamps).  This certification is being submitted 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 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.                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                                          \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                         (Signature)                                                                                                          (Date)  In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, 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. |