

**STATE OF DELAWARE  
FEDERAL FOOD COMMODITIES PROGRAM  
ELIGIBILITY TO TAKE FOOD HOME**

TEFAP Agency Delaware City Community Center

Revised 3/30/2020

Name: \_\_\_\_\_ Number of People in Household: \_\_\_\_\_

Address: \_\_\_\_\_

This table shows an annual 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

Household Size	Annual Income	Monthly Income	Weekly Income
1	23,606	1,968	454
2	31,894	2,658	614
3	40,182	3,349	773
4	48,470	4,040	933
5	56,758	4,730	1,092
6	65,046	5,421	1,251
7	73,334	6,112	1,411
8	81,622	6,802	1,570
For each additional family member add:	+8,288	+691	+160

**Income is less than listed on above income scale.**

You are also eligible to receive food from TEFAP if your household participates in any of the following programs. If you participate in one of these programs, please place a check next to the program.

\_\_\_\_\_ SNAP (FOOD STAMPS)      \_\_\_\_\_ Medicaid      \_\_\_\_\_ GA      \_\_\_\_\_ SSDI

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

**Please read the following statement carefully. Then sign the form and write in today's date.**

I certify that my annual 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 my household participates in the program that I have checked on this form. I also certify that, as of today, my household lives in the area served by the Delaware Emergency Food Assistance Program. This certification form is being completed 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 for the value of the food improperly issued to me and may subject me to criminal prosecution under State and Federal law.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Proxy Signature)

\_\_\_\_\_  
(Date)

Proxy Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_