TEFAP (USDA) Donated Commodities Application

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

I am applying to be an eligible recipient to receive USDA commodities.

I receive Food and Nutrition Services benefits (Food Stamps). ___ yes ___ no

My household's gross income is $_____monthly.

The number in my household is _____ persons.

Name:_____

Address:_____

_____

Phone #: _____ **County:** _____

IMPORTANT: READ THIS STATEMENT BEFORE SIGNING FOR FOOD(S).

I understand that any misrepresentation of need, sale, or misuse of the foods I have received is prohibited and could result in a fine, imprisonment, or both. (Sec. 211 E, PL 96-494 and Sec. 4C, PL 93-86 as amended)

Received by: _____

(Signature of Applicant)

Certifying Agency Representative: _____

(signature)

_____

(date)

DAVIDSON COUNTY COMMUNITY ACTION, INC.
15 E. 2ND AVENUE
LEXINGTON, NORTH CAROLINA 27292

APPLICATION FOR FOOD ASSISTANCE

NAME_____ADDRESS_____
CITY_____STATE_____ZIP CODE_____
TELEPHONE #_____SOCIAL SECURITY #_____
BIRTHDATE_____
MARITAL STATUS: S_____ M_____SEP_____DIV_____WID_____
PRESENT EMPLOYMENT INFORMATION: _____
_____

FAMILY MEMBERS	AGES	SOURCES OF INCOME	AMOUNT MONTHLY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REASON FOR APPLYING:
( ) No Food Stamps ( ) Awaiting Approval for Food Stamps ( ) Check Late ( ) Fire
( ) Unemployed/ Illness ( )Theft/Loss of Check/Food Stamps ( ) Other

CURRENTLY RECEIVING: FOOD STAMPS ___AMOUNT: $_____WIC_____
MEDICAID _____ SECTION 8 _____ AMOUNT: $ _____ OTHER:_____

OTHER AGENCIES ASSISTING: Social Services_____ Health Depart._____Churches_____
CAN YOU REEIVE ASSISTANCE FROM RELATIVES? _____
HAVE YOU ASKED FOR HELP FROM OTHER ORGANIZATIONS OR CHURCHES?
IF YES PLEASE LIST _____
WHAT IS YOUR MOST URGENT NEED? _____
OTHER INFORMATION (not given above) _____

I certify that the above information is correct and make application to Davidson County Community Action, Inc for emergency food help. I give my permission for Davidson County Community Action, Inc to make any necessary investigation to confirm this application and my needs.

_____ _____
Signature of Applicant Date

Approved/Denied
This help is as follows: