Indiana State Department of Health

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The Emergency Food Assistance Program (TEFAP)
Effective April 01, 2017

PLEASE PRINT

Name: _____

Address: _____

Zip Code: _____ Number in Household: _____

GRAY AREA OPTIONAL: # Adults: _____ # Children _____ # Seniors _____

I HEREBY CERTIFY THAT MY HOUSEHOLD INCOME IS AT OR BELOW THE FOLLOWING GUIDELINES:

INCOME GUIDELINES (185%)

HOUSEHOLD SIZE	HOUSEHOLD INCOME (Monthly)	(Annual)	HOUSEHOLD SIZE	HOUSEHOLD INCOME (Monthly)	(Annual)
1	$1,860	$22,311	4	$3,793	$45,510
2	$2,504	$30,044	5	$4,437	$53,243
3	$3,149	$37,777	6	$5,082	$60,976

For each additional household member add $645.00 per month

I ACKNOWLEDGE THAT THE STATE OF INDIANA AND THIS DISTRIBUTION AGENCY HAVE NO CONTROL OVER THE MANUFACTURING OF THIS DONATED PRODUCT AND CONSEQUENTLY DO NOT WARRANT THE CONDITION, QUALITY, OR CONTENT OF THE USDA DONATED COMMODITY.

Date	Signature	Date	Signature

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