House of Help
Application for Assistance

Please answer all questions so that we may serve you better. This information will not be shared with any other outside agency or entity others than the Houston Food Bank for reporting purposes.

CLIENT DOCUMENTATION (client may fill this out) **Date: _____**

Are you homeless? _____ Are you a veteran? _____ **Are you Head of the household?** _____

YOUR NAME	
STREET ADDRESS	
CITY / STATE/ ZIP/ COUNTY	
Mailing Address If different	
PHONE	Phone Belongs to: Client Relative Friend (circle one)
Date Of Birth	Allergic Food Diabetic
Proof of Address	Utility Bill ☐ Lease Agreement ☐ Car Insurance ☐ Other ☐
If unable to pick up groceries, who is allowed to pick up for you?	

Are you?

African American	Asian	Caucasian	Hispanic	Native American	Other

How many people live in your house in the following age: (please write the number in the box?)

Infant-17	18-64 yrs	65 and over

Does your family receive any type of assistance? ***Check all that apply***

Temporary Assistance To Needy Families (TANF / AFDC)		**SNAP (Food Stamps)**	
SSI		**Medicaid**	
CHIP		**WIC**	

Employed? ____ Retired? _____ Social Security?____ Disability Benefits? ____ Veteran's Benefits?____

The Total Gross Income (the amount before deductions) from ALL sources of every household member is:

GROSS INCOME	$	**Per Year**		**Per Month**		**Per Week**	

If Unemployed, are you registered with WorkSource Office here in Hempstead: _____Yes _____No

Was there an emergency situation that caused you to need food? _____

If yes, please state situation	

Please list the following information for any People living with you in your home:

Name	DOB	Gender	Allergic Food	Diabetic	Relationship

Special Ed Child in home: ___Yes ___No School Lunch Program: ___Yes ___No

Applied for Food Stamps: ___ YES ___ NO **Amount received per month $_____**

Other organizations giving you help? _____

Recent financial or health problems: _____

What assistance is needed at this time _____

Do you attend Church? _____ **Which one**:_____

Referred by: _____

***Nondiscrimination Statement:**
In accordance with federal law and USDA policy, this institution is prohibited from discriminating on the basis of race, color, national orgin, sex, age, ord disability.
To file a complaint of discrimination, write USDA, Director, Office of Adjudication and compliance, 1400 Independence Ave, SW, Washington D.C. 20250-9410, or call 1-202-260-1026, 1-866-632-9992 (toll free) or 1-202-401-0216 (TDD). USDA is an equal opportunity provider and employer

I declare the information I have given on this application to be true and correct. I certify that I am a member of the household listed above and that on behalf of this household I have applied for USDA Products. I certify that all information regarding my household is true to the best of my knowledge. I also designate the following person as an authorized representative of my household and certify that their information is correct to the best of my knowledge. Authorized representative is able to pick up product for client until re-certification is necessary.

I hereby authorize and give my permission to the House of Help to discuss and/or release my information to any agency I am referred to that may be able to assist me with my needs. I understand referrals are not a guarantee for further assistance.

_____

Client Signature (client must be present for initial interview and food assistance) **Date**

Hold Harmless and Indemnity Agreement

This Hold Harmless and Indemnity Agreement is between House Of Help and Faith United Church and the Undersigned (hereinafter referred to as "Releasor"). The parties agree as follows:

Whereas, Releasor desires to use House Of Help or Faith United Church premises, facilities and services, including but not limited to House Of Help's food pantry and intake office, and in consideration of such use and services, Releasor agrees that:

House Of Help and Faith United Church, its officers, directors, agents, employees, successors and assigns, shall not be liable or responsible for, and shall be saved and held harmless and indemnified by Releasor from and against any and all suits, actions, losses, damages, claims, or liability of any character, type, or description, including all expenses of litigation, court costs, and attorney's fees for injury or death to any person, or injury to any property, received or sustained by any person or persons or property, arising out of or occasioned by, directly or indirectly, the provision by House Of Help and Faith United Church of services, programs, facility use, consumption of food or food products, and/or any other incident arising of House Of Help and Faith United Church property, including claims and damages arising in part from the negligence of House Of Help or Faith United Church, its officers, directors, agents, and/or employees.

IT IS THE EXPRESS INTENT OF THE PARTIES TO THIS AGREEMENT THAT THE INDEMNITY EXTENDED BY THE RELEASOR TO INDEMNIFY AND PROTECT HOUSE OF HELP AND FAITH UNITED CHURCH FROM THE CONSEQUENCES OF HOUSE OF HELP AND FAITH UNITED CHURCHS'S OWN NEGLIGENCE, WETHER THAT NEGLIGENCE IS THE SOLE OR CONTRIBUTORY CAUSE OF THE RESULTANT INJURY, DEATH, OR DAMAGE. RELEASOR EXPRESSLY AGREES THAT THIS AGREEMENT IS INTENDED TO BE AS BROAD AND INCLUSIVE AS PERMITTED BY THE LAWS OF THE STATE OF TEXAS.

Date This _____ Day Of _____ 20___

Releaser
Signature: _____

Printed Name: _____

The Emergency Food Assistance Program (TEFAP)

Participant Agreement, Rights, Obligation, and Fair Hearing Request

1. I certify that information I have provided for eligibility determination is correct to the best of my knowledge. Program officials may verify information on this form.
2. Program benefits are provided in connection with the receipt of the federal assistance. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under state and federal law.
3. I may appeal any decision made by the contracting entity (Food Bank) or distribution site regarding my eligibility for this program. I can submit a request for a fair hearing to the distribution site.
4. I understand that I may not receive USDA Foods to more than one distribution site unless granted permission from the food bank that administers TEFAP in my service area.
5. I understand that if I choose to send alternate person (a Proxy) to pick up my food, that person must be listed as an alternate on my Household Application for USDA Foods.
6. I understand that the food provided by this program is intended for the members of the eligible household.
7. I understand that I must not sell or exchange USDA Foods for nonfood items.
8. I consent to the release for information to TEFAP staff, which includes officials of United States Department of Agriculture, Texas Department of Agriculture, and the food bank.
9. Program staff have advised me of my rights and obligations under this program.
10. I understand that the standards for participation in this program are the same for everyone regardless for race, color, National origin, age sex or disability.
11. I understand that I have the right to request a fair hearing of the denial or termination of benefits through and administrative review of the adverse action. A request for a fair hearing can be submitted to the food bank or distribution site.
12. I have read this form, or the form has been read to me.
13. I understand that I must not physically abuse or threaten or physically abuse program staff.

I accordance with Federal civil rights law and US 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 discrimination 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, American Sign Language, etc.) should contact the Agency (State or local) where thy 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 then English.

To file program complaints of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at: http://www.ascr.usda.gove/complain_filing_cust.html and at any USDA office, or write a letter addressed to USDA and provide in letter all 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

Participant's Signature

Program Official's Signature

Date

Date