Revised: 11.11.24

HOPE
St. Vincent's House

Today's Date:

HEAD OF HOUSEHOLD: Please fill out the section below for the head of your household.

1 **First name**

Last name

2 **HOUSEHOLD INFO**

☐ **If you are homeless, check this box** and skip this question

Address

City / State / Zip / County

Email (optional)

Phone Number
(_____) - _____ - _____

SSN (optional)
_____ - ____ - _____

3 **Date of Birth**

3A **Veteran Status**
Yes ☐ No ☐

4 **Education**
- ◯ Some high school
- ◯ High school grad
- ◯ GED
- ◯ Some college
- ◯ College degree
- ◯ Other:

5 **Employment**
- ◯ Working
- ◯ Not working
- ◯ Unable to work / disabled
- ◯ Retired
- ◯ Other:

6 **Sex**
- ◯ Male
- ◯ Female
- ◯ Transgender man
- ◯ Transgender woman
- ◯ Other:

7 **What is the total income of all household members (per month)?** *(gross income before deductions)*

8 **How many people in your household are...** *(write the numbers in the boxes below ↴)*

Under 18 years old

18 to 59 years old

60 and over

9 **Race / Ethnicity**
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other:

10 **Does your household receive any of the help listed below?** *(mark those that apply)*
- ☐ TANF
- ☐ SNAP (Food Stamps)
- ☐ CHIP
- ☐ SSI
- ☐ Medicaid
- ☐ WIC
- ☐ ***None of the above***

***Please continue to complete this application on the next page.**

VERY IMPORTANT

11 **Please explain in the box below your emergency situation that caused you to need food:**

OTHER INDIVIDUALS IN THE HOUSEHOLD

Please fill out the following information for <u>each additional person</u> in the household *(besides the head of the household)*

12 **First & Last Name**

Phone Number

Date of Birth MM / DD / YYYY **Age** (in years)

Sex Male ☐ Female ☐ Other ☐

Race Black ☐ Hispanic ☐ White ☐ Other ☐

Person's relation to you
(e.g. child, spouse, roommate)

Veteran? Y ☐ N ☐

SSN (optional) _____ - _____ - _____

13 **First & Last Name**

Phone Number

Date of Birth MM / DD / YYYY **Age** (in years)

Sex Male ☐ Female ☐ Other ☐

Race Black ☐ Hispanic ☐ White ☐ Other ☐

Person's relation to you
(e.g. child, spouse, roommate)

Veteran? Y ☐ N ☐

SSN (optional) _____ - _____ - _____

***Please continue to complete this application on the next page.**

14 **First & Last Name**

Phone Number

Date of Birth MM / DD / YYYY **Age (in years)**

Sex Male ☐ Female ☐ Other ☐

Race Black ☐ Hispanic ☐ White ☐ Other ☐

Person's relation to you
(e.g. child, spouse, roommate)

Veteran?
Y ☐ N ☐

SSN (optional)
_____ - _____ - _____

15 **First & Last Name**

Phone Number

Date of Birth MM / DD / YYYY **Age** (in years)

Sex Male ☐ Female ☐ Other ☐

Race Black ☐ Hispanic ☐ White ☐ Other ☐

Person's relation to you
(e.g. child, spouse, roommate)

Veteran?
Y ☐ N ☐

SSN (optional)
_____ - _____ - _____

16 **First & Last Name**

Phone Number

Date of Birth MM / DD / YYYY **Age** (in years)

Sex Male ☐ Female ☐ Other ☐

Race Black ☐ Hispanic ☐ White ☐ Other ☐

Person's relation to you
(e.g. child, spouse, roommate)

Veteran?
Y ☐ N ☐

SSN (optional)
_____ - _____ - _____

***Please continue to complete this application on the next page.**

Sign below if you are applying for assistance from the Galveston County Food Bank ↴

X_____ _____

Date

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

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…

Name of Authorized Representative: (not name of family member only person to act on their behalf)

Authorized Representatives Address:

Nondiscrimination Statement: 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: 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 (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.
This institution is an equal opportunity provider.

To Be Completed By Staff

AGENCY DOCUMENTATION – GCFB Eligibility

☐ Household is ELIGIBLE based on…	☐ Household is INELIGIBLE
☐ Low income ☐ Receipt of TANF/AFDC ☐ Receipt of SNAP (food stamps) ☐ Receipt of SSI ☐ Receipt of Medicaid ☐ Emergency Food Need ↴	☐ Income level over 185% listed on Annual Income Guidelines ☐ it is not an emergency situation and does not meet any other criteria ☐ Other: *clients denied USDA products should be referred to the HFB for review
If "emergency need" please describe below. Clients in this category may be served no more than 6 months unless another emergency can be documented. **Emergency need comments:**	

If household is eligible based on criteria above ↴

Certification Period: Start Date: _____ End Date: _____

Agency Staff Initials: _____ Revisit form on: _____