



All information provided on this form is voluntary. However, all information is helpful as we develop programs and apply for funding.

# INTAKE FORM

Today's date: \_\_\_/\_\_\_/\_\_\_

## Program Participant

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender:  Male  Female Transgender:  Yes  No

Check if Homeless

## Address

Number Street Apt# City Zip code

Phone Number ( ) -

Race (Please circle) African Asian/SE Pacific Islander Multiracial  
African American/Black Caucasian/White Other  
American Indian Hispanic/Chicano/Latino

Ethnicity  Hispanic/Latino  Non-Hispanic/Latino

Primary language: \_\_\_\_\_

Do you have a disability?:  Yes  No If yes, what type of disability? \_\_\_\_\_

## How did you hear about Keystone:

Church  Friend/Family  Other agency  Publication  School  United Way/211

## Education Level

8<sup>th</sup> grade or less  Some college/postsecondary training  
 Less than a high school diploma  College graduate, degree: \_\_\_\_\_  
 High school diploma/GED  Other \_\_\_\_\_

## Work Status

Employed full time  Unemployed and seeking work  
 Employed part time  Unemployed due to disability  
 Seasonal employment  Retired

Average hours per week: \_\_\_\_\_  
Hourly pay: \_\_\_\_\_

## Type of Housing

Rent  Own  Homeless/No permanent housing  Temporary

Monthly rent/mortgage payment: \$ \_\_\_\_\_

Do you receive:  Section 8 subsidy  Subsidy other than Section 8

Please turn over and complete the other side of this form

Other Household Members

| First Name | Last Name | Date of Birth  | Gender | Race  | Relationship to You | Disability (Y/N)<br>What Type? |
|------------|-----------|----------------|--------|-------|---------------------|--------------------------------|
| _____      | _____     | ____/____/____ | _____  | _____ | _____               | _____                          |
| _____      | _____     | ____/____/____ | _____  | _____ | _____               | _____                          |
| _____      | _____     | ____/____/____ | _____  | _____ | _____               | _____                          |
| _____      | _____     | ____/____/____ | _____  | _____ | _____               | _____                          |
| _____      | _____     | ____/____/____ | _____  | _____ | _____               | _____                          |

Income of ALL Household members

|                              | Monthly Amt. | Child support | Monthly Amt. | Monthly Amt. |
|------------------------------|--------------|---------------|--------------|--------------|
| All household employment     | _____        | _____         | SSDI         | _____        |
| Unemployment                 | _____        | MFIP/DWP      | Other        | _____        |
| Social Security (retirement) | _____        | Pension       | SNAP         | _____        |
| General Assistance (GA)      | _____        | Worker's Comp |              | _____        |

|  |
|--|
| Total Monthly Household Income<br>\$ _____ |
|--|

Consent to Use the Basic Needs Program

I have read and agree to the following:  
I understand that the Basic Needs Program is for those who have an emergency need and that residents and homeless individuals living in this area can receive food from the food shelf once each month except in situations of emergency and distress due to disasters. I agree to accept the food "as is". I release both the original donor and Keystone Community Services from any liability resulting from the condition of the food. I agree that I will not sell the food that I receive. If I do sell this food, I may not be eligible to use this food shelf in the future.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Minnesota: The Emergency Food Assistance Program (TEFAP)  
Annual Eligibility Form  
United States Department of Agriculture (USDA)**

\_\_\_\_\_  
Keystone Community Services  
(Name of Food Shelf or Distribution Site)

Name: \_\_\_\_\_

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

I am eligible to receive TEFAP commodity food because I am in Minnesota and because my household income is 200% or less of the Federal Poverty Guidelines. Eligibility is granted to all persons in situations of emergency and distress due to disasters. I am also eligible if I receive or participate in the following services and programs:

**OPTIONAL: Check the program(s) in which you participate:**

- |   |  |
|---|--|
| <input type="checkbox"/> MFIP – Minnesota Family Investment Program         | <input type="checkbox"/> Child Care Assistance |
| <input type="checkbox"/> GA – General Assistance                            | <input type="checkbox"/> Head Start            |
| <input type="checkbox"/> SNAP – Supplemental Nutritional Assistance Program | <input type="checkbox"/> Section 8             |
| <input type="checkbox"/> NAPS – Nutritional Assistance Program for Seniors  | <input type="checkbox"/> Public Housing        |
| <input type="checkbox"/> WIC – Women, Infants, and Children                 | <input type="checkbox"/> Energy Assistance     |
| <input type="checkbox"/> Free and reduced breakfast and lunch               | <input type="checkbox"/> Weatherization        |

**Income Eligibility: (200% of Federal Poverty Guidelines)**

| Family size | Annual Income       |
|-------------|---------------------|
| One         | \$0 - \$24,980      |
| Two         | \$24,981 - \$33,820 |
| Three       | \$33,821 - \$42,660 |
| Four        | \$42,661 - \$51,500 |
| Five        | \$51,501 - \$60,340 |
| Six         | \$60,341 - \$69,180 |
| Seven       | \$69,181 - \$78,020 |
| Eight       | \$78,021 - \$86,860 |

Add \$8,840 of allowable income for each additional family member.

|   |
|---|
| <p>Number of people in household:</p> <p><input type="checkbox"/> Children ages 0-17</p> <p><input type="checkbox"/> Adults ages 18-64</p> <p><input type="checkbox"/> Seniors ages 65+</p> |
|---|

**Data Privacy Notice/Tennessee Warning**

You have rights under the Minnesota Government Data Practices Act. This Act protects your privacy. We are asking for information so we can: tell you apart from other persons with a similar name and decide how to serve you best.

Generally, you are not required to give us the information. However, without it, we can't report accurate statistics which affects funding. The law allows us to share your information (the number of children, adults, and seniors in your household and the number of pounds of food received) with staff from the Department of Human Services, Hunger Solutions Minnesota, and your regional food bank.

You also have the right to copies of information we have about you. If you do not understand the information, it may be explained to you. If you do not think the information is accurate or complete, please correct it with the food shelf staff.



**Permission for someone else to pick up my food:**

If it's hard for you to get food from the food shelf, you have the option to select someone else to pick up your food.

I give permission to:

\_\_\_\_\_ (name) to pick up my food.

I understand I have the right to:

- Change who I choose to pick up my food. I will need to fill out a new form for any changes.
- Let the food shelf staff know if I want to cancel my permission.

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: [How to File a Complaint](#), 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date