Indiana State Department of Health
The Emergency Food Assistance Program (TEFAP)
Effective January 2020

PLEASE PRINT
Name: ____

Address: ____

Zip Code: _________________ Number in Household: _______________________________

MY HOUSEHOLD PARTICIPATES IN (automatic eligibility for TEFAP):

Women, Infants, and Children (WIC) ☐

Supplemental Nutrition Assistance Program (SNAP)☐

National School Lunch Program (NSLP)☐

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

INCOME GUIDELINES (185%)

HOUSEHOLD SIZE	HOUSEHOLD INCOME		HOUSEHOLD SIZE	HOUSEHOLD INCOME	
	(Monthly)	(Annual)		(Monthly)	(Annual)
1	$1,926	$23,107	4	$3,970	$47,638
2	$2,607	$31,284	5	$4,652	$55,815
3	$3,289	$39,461	6	$5,333	$66,992

For each additional household member add $682.00 per month

OPTIONAL: _____ # 0-5 _____ #6-17 _____#18-54 _____#55-59 _____#60-64 _____#65+ _____# Veteran

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Date	Signature	Date	Signature

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