Children (0-17) _____

Adults _____

Seniors (60 and up) _____

Pennsylvania
Department of Agriculture

Bureau of Food Assistance

The Emergency Food Assistance Program (TEFAP)

"Self Declaration of Need"

Effective July 1, 2026 to June 30, 2027

Recipient Name

Agency Representative Signature — Date

Recipient County of Residence

Red Land Senior Center — Distribution Site Name

80043 — Number

Recipient Zip Code

501 Market Street, Lewisberry, PA 17339 — Distribution Site Location

The Emergency Food Assistance Program is operated in accordance with United States Department of Agriculture (USDA) policy, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. Eligibility is based upon the income guidelines listed below. The recipient circles the entire line that applies to their Household Size, understanding they must be at, or below, the income level indicated to be eligible for program benefits.

Total Household Income (based on 185% of Poverty)						
Household Size Circle One		**Annual**		**Monthly**		**Weekly**
1	$	29,526	$	2,461	$	568
2	$	40,034	$	3,337	$	770
3	$	50,542	$	4,212	$	972
4	$	61,050	$	5,088	$	1,175
5	$	71,558	$	5,964	$	1,377
6	$	82,066	$	6,839	$	1,579
7	$	92,574	$	7,715	$	1,781
8	$	103,082	$	8,591	$	1,983
For each additional family member add:	$	10,508	$	876	$	203

By signing below, I declare that my income from all sources does not exceed the income listed above for households with the same number of people as my household. I also certify that, as of today, my household lives in the area served by Pennsylvania in The Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of Federal assistance. I understand that these records will be held in confidence at this distribution site but may be released to the Pennsylvania Department of Agriculture or the United State Department of Agriculture for review upon their request.

Recipient Signature — **Date**

Return completed form to your designated county agency. If you are unsure of the correct agency, please call the Bureau at 1-800-468-2433.

THIS FORM IS NOT TO BE ALTERED OR CHANGED IN ANY WAY.

PLEASE REFER TO THE REVERSE SIDE OF THIS DOCUMENT FOR AN IMPORTANT USDA NON-DISCRIMINATION STATEMENT

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. fax:
(833) 256-1665 or (202) 690-7442; or

3. email:
program.intake@usda.gov

This institution is an equal opportunity provider.

The Emergency Food Assistance Program
Pennsylvania TEFAP Proxy Form

Date _____

I_____ hereby authorize _____ to pick up my TEFAP Food Package and deliver it to me.

_____ _____
Client Signature Proxy Signature

☐ Proxy ID Verified

_____
Pantry Representative