

| | | | | |
|-----------------------------|--|--|---|------------------------|
| Your First Name: _____ | | M.I. _____ | Your Last Name: _____ | |
| Birthdate: _____ | | Gender Identification: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other | | Social Security: _____ |
| Phone Number: _____ | | | Email (opt.): _____ | |
| Living Address: | | | Mailing Address: <input type="checkbox"/> Same as living address | |
| Street: _____ Apt. #: _____ | | | Street: _____ Apt. #: _____ | |
| Town: _____ | | | Town: _____ | |
| State: _____ Zip: _____ | | | State: _____ Zip: _____ | |

House Apartment Community Shelter Homeless – No Housing Hotel/Motel Room

Demographics:

White/Caucasian Asian Black/African American Indian Pacific Islander Bi-racial
 Prefer not to answer

Are you Hispanic or Latino? Yes No Prefer not to answer

| | |
|--|--|
| Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No | Military Service: <input type="checkbox"/> Never <input type="checkbox"/> Veteran <input type="checkbox"/> Active Duty |
|--|--|

| | |
|--|--|
| Do you receive WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Program for pregnant /nursing /young children)</i> | Do you receive 3SquaresVT/ EBT? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please let us know if you would like an application.</i> |
|--|--|

| | |
|--|--|
| Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check type- <input type="checkbox"/> Medicaid <input type="checkbox"/> VT Health Connect <input type="checkbox"/> Medicare <input type="checkbox"/> Employment Based <input type="checkbox"/> Other | Your Highest Level of Education: <input type="checkbox"/> Up to 8 th grade <input type="checkbox"/> Associate's degree <input type="checkbox"/> Some high school (no diploma) <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> High school diploma or GED <input type="checkbox"/> Graduate studies <input type="checkbox"/> Some college (no degree) <input type="checkbox"/> Graduate degree |
|--|--|

Work status: Work full time Work part time Currently unemployed Not in labor force Retired

Other FAMILY members who live in the household and generally eat together

None

| | First and Last Name | DOB | Gender | Relationship to you |
|---|---------------------|-----|--------|---------------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |

Please continue on other side

Data entry

MONTHLY INCOME

- Please fill in **monthly dollar amount** in the chart below for family members who receive income. Roommate/ housemate/personal attendant income does not need to be included.
- 3SquaresVT is NOT considered cash income and does not need to be listed.

NO ONE in my household has any income at this time.

| <i>Types of income</i> | <i>You</i> | <i>Your Spouse/ Partner</i> | <i>Other Adult(s)</i> |
|--|------------|---------------------------------|-----------------------|
| Wages (Job or Self-employed) | \$ | \$ | \$ |
| Social Security (Retirement) | \$ | \$ | \$ |
| SSI or SSDI (Disability) | \$ | \$ | \$ |
| Reach Up (TANF) | \$ | \$ | \$ |
| Child Support | \$ | \$ | \$ |
| Other income sources: <input type="checkbox"/> General Assistance <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Pension <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> _____ | \$ | \$ | \$ |
| <i>Totals by column</i> | \$ | \$ | \$ |

Confidentiality Policies

It is our policy at Capstone Community Action to respect your privacy, guard your personal information, and to keep you informed of your rights. We comply with the State of Vermont Agency of Human Services Consumer information and Privacy Rule. By signing below, you are providing informed recognition of your rights under said rule.

Program Administration: Capstone Community Action staff will use and share individually identifiable information as required by our funding sources for the purpose of program administration. Examples include reporting, billing, and recordkeeping.

Mandated Reporting

VT state law: "Any mandated reporter who reasonably suspects abuse or neglect of a child shall report in accordance with the provisions of Section 4914 of the Title within 24 hours of the time information regarding the suspected abuse or neglect was first received or observed." [33 V.S.A. § 4913(c)].

"Any [mandated reporter] who knows of or has received information of abuse, neglect, or exploitation of a vulnerable adult or who has reason to suspect that any vulnerable adult has been abused, neglected, or exploited shall report or cause a report to be made in accordance with the provisions of Section 6904 of this title within 48 hours." [VSA Title 33 Chapter 069].

Capstone Community Action shares an important responsibility with the Dept. for Children and Families (DCF), the Dept. of Disabilities, Aging and Independent Living (DAIL), and all Vermonters, keeping children and vulnerable adults safe and ensuring they live in safe, supportive, and healthy environments.

Certification

By signing this document, I give my word that the information I provide in this application is true and complete to the best of my knowledge. I understand that, if I knowingly provide false information, assistance may be denied.

Our Discrimination Policy

Capstone Community Action honors community diversity and does not discriminate in hiring or providing services on the basis of race, color, culture, language, national origin, religion, creed, political affiliation, family composition, marital status, sexual orientation, class, gender/gender identity, age, mental/sensory/physical disabilities.

Your Signature: _____ **Date:** _____

Capstone Use: Annual Household Income: \$ _____ # people _____ Tefap



Statement of Eligibility to Receive USDA Foods from The Emergency Food Assistance Program (TEFAP)

Name: _____ Number in household: _____

Address (optional): _____

Phone Number (optional): _____
(phone number may be used to notify you if there is a food safety recall)

TEFAP Income Eligibility Guidelines Effective July 1, 2024 - June 30, 2025

| Household Size | Yearly | Monthly | Twice Per Month | Every Two Weeks | Weekly |
|--|-----------|----------|-----------------|-----------------|---------|
| 1 | \$45,180 | \$3,765 | \$1,883 | \$1,738 | \$869 |
| 2 | \$61,320 | \$5,110 | \$2,555 | \$2,359 | \$1,180 |
| 3 | \$77,460 | \$6,455 | \$3,228 | \$2,980 | \$1,490 |
| 4 | \$93,600 | \$7,800 | \$3,900 | \$3,600 | \$1,800 |
| 5 | \$109,740 | \$9,145 | \$4,573 | \$4,221 | \$2,111 |
| 6 | \$125,880 | \$10,490 | \$5,245 | \$4,842 | \$2,421 |
| 7 | \$142,020 | \$11,835 | \$5,918 | \$5,463 | \$2,732 |
| 8 | \$158,160 | \$13,180 | \$6,590 | \$6,084 | \$3,042 |
| For each additional household member add | \$16,140 | \$1,345 | \$673 | \$621 | \$311 |

Do not count any benefits from 3SquaresVT as part of your income when deciding if you meet these guidelines.

By signing below, I certify that I am eligible to receive USDA Foods from TEFAP because my household income is at or below the above guidelines, and I live in the State of Vermont.

| Signature | Date |
|-----------|------|
| | |

USDA Regulations require that you sign this statement the first time that you receive USDA Foods from TEFAP during the period of eligibility. The period of eligibility runs July 1 - June 30. This statement will be kept on file at the food pantry where you receive USDA Foods from TEFAP.

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, audiotope, 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