



Everyday Eats Application



Name of Applicant		Case No.	
Telephone Number		County	
Physical Address (Street, City, Zip Code)			
Mailing Address (If Different) (Street, City, Zip Code)			
Applicant's Date of Birth		Total No. Living In Household	
Names of Qualifying Household Members		Age	Date of Birth
			Case Number (For Agency Use Only)

RACIAL ETHNIC DATA (OPTIONAL) Please note: if you choose not to disclose your race and ethnicity, the agency will designate a race and ethnicity based on their observation.

Are you of Hispanic or Latino origin? (For statistical purposes only) YES NO

What is your race? (Select one or more) American Indian or Alaskan Native Asian
 Black or African American Native Hawaiian or Pacific Islander White

2024 Income Eligibility Guidelines		
Household Size	Monthly Household Income	Annual Household Income
1	\$1,632	\$19,578
2	\$2,215	\$26,572
3	\$2,798	\$33,566
4	\$3,380	\$40,560
5	\$3,963	\$47,554
For Each Additional Family Member, Add	\$583	\$6,984

Indicate the source and amount of last month's income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income includes commissions, strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, monthly income may be calculated as the household's average income during the previous 12 months.

Type of Income	Monthly Household Income	Annual Household Income
Gross Salary, Wages		
Social Security		
Pensions/Retirement		
Self-Employment		
Unemployment		
Other Income		
Total Household Income		

Program participants must report changes in household income or composition within 10 days after the change becomes known to the household.

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the program are the same for everyone regardless of race, color, national origin, sex, age, and disability.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the Program.

✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.

✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I am also aware that I may not receive Everyday Eats benefits at more than one Everyday Eats site at the same time. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.)

YES NO

Applicant Signature	Date
Waiting List Certification Signature	Date

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;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

*** * * * * FOR CERTIFYING AGENCY USE ONLY * * * * ***

I have verified the following for each applicant: Check all that apply. <input type="checkbox"/> Identification (List type of ID) <input type="checkbox"/> Age <input type="checkbox"/> Place of Residence <input type="checkbox"/> Household members	Applicant is: <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible Is caseload available? <input type="checkbox"/> Yes <input type="checkbox"/> No Date notice is provided to the applicant: Certification Period First Month: _____ Last Month: _____
--	---

Certifying Official Signature and Date: