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

Effective April 1, 2009

Please Print
PANTRY
NAME________________________________COUNTY____________________

PANTRY ADDRESS______________________________CITY________________________

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

INCOME GUIDELINES
(165%)

HOUSEHOLD SIZE	HOUSEHOLD INCOME (Monthly)	(Annual)	HOUSEHOLD SIZE	HOUSEHOLD INCOM E (Monthly)	(Annual)
1	$1,489	$17,868	4	$3,032	$36,384
2	$2,003	$24,036	5	$3,546	$42,552
3	$2,518	$30,216	6	$4,060	$48,720

For each additional household member add $312/$3,740

I ACKNOWLEDGE THAT THE STATE OF INDIANA AND THIS DISTRIBUTION AGENCY HAVE NO CONTROL OVER THE MANUFACTURING OF THIS DONATED PRODUCT AND CONSEQUENTLY DO NOT WARRANT THE CONDITION, QUALITY, OR CONTENT OF THE USDA DONATED COMMODITY.

DATE	SIGNATURE	ADDRESS	CITY	ZIP	NUMBER IN HOUSEHOLD