INTAKE FORM

File updated: 5/9/25

We ask for basic information to better understand who we serve and advocate for the needs of our community. You only need to fill it out once. Please fill this out today and leave it with a volunteer. Please write legibly and fill out as many fields as you can.

Full Name: FIRST NAME | LAST NAME

Date of Birth: / / (MONTH / DAY / YEAR)

Phone: ( ) -

☐ It is OK to Contact me

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other:

Race: *selectall that apply

☐ White ☐ Hispanic, Latino, Spanish ☐ Black / African American ☐ Asian ☐ American Indian ☐ Middle Eastern, Northern African

☐ Hawaiian / Pacific Islander ☐ Other: ☐ Do not know / Prefer not to say

Contact: Address: Street City State Zip

Household: (DEPENDENTS) Please complete information for OTHER MEMBERS of your household:

Full Name	Date of Birth (Month Day Year)	OR	Age	Gender	Race
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			
	/ /	OR			

Is anyone in your household receiving SNAP or Food Stamps? This question does not impact service.

☐ Yes ☐ No ☐ Don't know / Prefer not to say

If you would like moreinformation about SNAP, call 1-855-444-5556 (Nebraska residents) or 1-855-944-3663 (Iowa residents)

Questions? Ask a staff member or visit FoodBankheartland.org/Service-Insights

FOODBANK FOR THE HEARTLAND | PARTNER FOOD BANK OF FEEDING AMERICA

Proxy Consent Form

Please Complete (TEFAP) Emergency Food Assistance Program Beneficiary Information Below

Beneficiary Name _____

Address _____

City and Zip Code _____

Phone Number _____

I hereby designate: _____ _____ (Name of Proxy)
First Last

To serve as my proxy to sign required documents, and pick-up my food benefits from the following agency:

_____ _____
Name of Agency City

I understand that I take full responsibility for the actions of my proxy. I will inform him or her of the proper procedures when acting on my behalf. My signature declares my continued eligibility for food benefits.

_____ _____
Beneficiary Signature Date

_____ _____
Proxy Signature Date

Agency Use Only - Approved By:

_____ _____ _____
Print Name **Signature** **Date**

In accordance with Federal civil rights law and U.S. Department of USDA) civil rights regulations , the USDA, its , and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based , national , or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large , American , etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who , hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-
339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. Send your completed form or letter to us by mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights; 1400 Independence Avenue, SW; Washington, D.C. 20250-9410. By fax: (202) 690-7442 or email at program.intake@usda.gov.

This Institution is an Equal Opportunity Provider

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Children and Family Services
TheEmergencyFoodAssistanceProgram (TEFAP)

Eligibility to Take Food Home

I, the undersigned, agree to indemnify and hold harmless this Agent and the State of Nebraska, their Departments, officers, agencies, and employees from any and all claims, demands, damages costs, expenses, actions, and causes of action out of any act or occurrence pertaining to the issuance and acceptance of the USDA donated food items.

I further certify that my household's current gross income is equal to or below the current monthly income amounts or that I am participating in one of the following: Supplemental Nutrition Assistance Program (SNAP), Aid to Dependent Children (ADC), Aid to the Aged, Blind, and Disabled (AABD), Low Income Home Energy Assistance Program (LIHEAP), Medical only, State Disability, or Refugee Resettlement Program (RRP).

MonthlyIncome(180%oftheFederalPoverty Level)

Household Size	MonthlyIncomeAmount	Household Size	MonthlyIncomeAmount
1	$2,394	6	$6,654
2	$3,246	7	$7,506
3	$4,098	8	$8,358
4	$4,950	Each additional household member	Add $852
5	$5,802		

Please complete the following information:

Household Size:_____ Children under the age of 18 in the household? □Yes □ No

Address: _____

In accordance with Federal Civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, gender, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
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Signature: _____ Date: _____