

# EMERGENCY FOOD REGISTRATION FORM 2026

## Intake Information

Clients must be residents of the State of New Jersey

Revision date 2-2026

Date: \_\_\_\_\_ LDA LACEY FOOD BANK EFO Fulfill

Name (Print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Town & zip code (required): \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Number of adults in household: \_\_\_\_\_ Number of children under 18 in household: \_\_\_\_\_

### QUALIFYING REASON (PLEASE CIRCLE)

*A participant in one or more local state or federal programs at or below the income threshold established by the state agency for TEFAP eligibility will automatically qualify for TEFAP USDA Foods.*

1. **SELF DECLARATION - LOW INCOME (185% of poverty)**
2. **Existing Local, State or Federal Program participant (example – WIC)**
3. **DISASTER (Other – can be divorce, domestic violence, unusual expense, loss of employment, etc.)**

Please explain: \_\_\_\_\_

I am accepting a charitable donation of food from the Emergency Food Pantry. I hereby relinquish the Food Pantry of all liability of any nature whatsoever and accept the food products “as is” and at my own risk.

“I certify that my total yearly gross household income is at or below 185% of the poverty level, OR that my household participates in the program(s) that I have circled above. I will also notify the Pantry, if there are changes to my income or qualifiers which may cause me to become ineligible for the TEFAP USDA foods.”

CLIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

Interviewer Name: \_\_\_\_\_

Providing your address is optional, however any information you provide us with will help us to better serve you.

Street Address: \_\_\_\_\_ CASE ID: \_\_\_\_\_

In accordance with federal civil rights law and 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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

USDA is an equal opportunity provider, employer, and lender.

**FORM GETS MAILED TO:  
LACEY FOOD BANK  
102 Station Dr.  
Forked River, NJ 08731  
SEE OTHER SIDE**

NAME: \_\_\_\_\_

NUMBER OF ADULTS IN HOUSEHOLD: \_\_\_\_\_

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>DATE OF BIRTH</u>	<u>GENDER</u>

NUMBER OF ADULTS IN HOUSEHOLD: \_\_\_\_\_

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>DATE OF BIRTH</u>	<u>GENDER</u>

Head of Household  Yes  No

**CONSENTS** (Required):

I give my consent to be contacted by The FoodBank if I am found to be potentially eligible for additional assistance (SNAP, Food Stamps, Free Income Tax Preparation, Affordable Health Insurance, Utilities Assistance, etc.)\*

Yes  Did Not Give Consent

I give my consent to be contacted by The FoodBank to share my testimonial and highlight my hunger related experience.\*

Yes  Did Not Give Consent

I give my consent that my household information and assistance records will be shared through an electronic database, known as "Oasis Insight", with Fulfill. Fulfill is a non-profit organization that helps people identify and obtain assistance to which they may be lawfully entitled. I understand by participating in this database Fulfill may be able to assist me more effectively. I also understand that information provided by me for the Oasis Insight database may be shared with Oasis Insight participating food programs. Any assistance I receive will not be shared with participating food programs. This information may be used to create summary reports for program evaluation purposes.

This Release of Information will remain in effect until I make a written request to Fulfill or Pantry that I no longer wish to participate in Oasis Insight.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**DEMOGRAPHIC/ETHNICITY QUESTIONS:**

**Ethnicity:**

- White/Caucasian
- Native American or Alaska Native
- Black or African American
- Hispanic, Latino
- Asian
- Native Hawaiian or Other Pacific Islander
- Some Other Race or Origin

**Qualifying Reason for Assistance\*:** required

- 1-TANF
- 2-SNAP
- 3-SSI
- 4-WIC
- 5-Medicaid
- 6-Low Income
- 7-Disaster

**If SNAP, how much received monthly?**

\_\_\_\_\_

**IF DISASTER OR SPECIAL CIRCUMSTANCE:**

- Domestic Violence
- Family Tragedy
- Fire or Flood
- High Debt
- High Medical Bills
- High Utility Bills
- Loss of Employment
- SANDY
- Natural Disaster
- Temporary Disability
- Divorce             Other

**Household Type:**

- Single/Individual Household
- Single Parent W/Children under 18
- Two Parents W/Children under 18
- Grandparents Raising Children under 18
- Married/Partner w/No Children
- Other
- All Adults

**Employment Status of Head of Household:**

- Employed
- Unemployed
- Retired and Not Working
- Disabled and Can't Work
- Can't Work for Other Reason

**How Many People in Your Household are working?**

- 0
- 1
- 2
- 3 or more

**Number of Adults Age 60 or Older?**

- 0
- 1
- 2
- 3 or more

**Marital Status:**

- Single, never married
- Married or living as married
- Separated or divorced
- Widowed
- Single
- Divorced

**Highest Education Completed by Anyone:**

- Less than high school
- High school diploma/GED
- Vocational school
- Some college beyond high school or 2-year college degree
- 4-year college degree or higher

**Race of Applicant:**

- White/Caucasian
- Black or African American
- Hispanic, Latino
- Native American or Alaska Native
- Asian
- Middle Eastern
- Native Hawaiian or Other Pacific Islander
- Some Other Race or Origin

**Primary Language Spoken by Adults in Your Home?**

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> English    | <input type="checkbox"/> Russian        |
| <input type="checkbox"/> Spanish    | <input type="checkbox"/> German         |
| <input type="checkbox"/> Chinese    | <input type="checkbox"/> Hmong          |
| <input type="checkbox"/> French     | <input type="checkbox"/> Haitian Creole |
| <input type="checkbox"/> Tagalog    | <input type="checkbox"/> Arabic         |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Korean     |   |

**Current Living Situation:**

- House or apartment
- Mobile home or house trailer
- Rented room in motel or boarding house
- Shelter, mission, or transitional living situation
- Double up – temporarily staying with family/friends
- No housing
- At risk of being homeless

**Do you currently have?**

- Stove
- Microwave
- Hot Plate
- Refrigerator
- Grill
- Full Kitchen
- None of these

**Is Anyone in Your Household Pregnant?**

- Yes
- No

**How Do You Usually Get To This Program?**

- Walk
- Bike
- Take a bus or train
- Get ride from family/friend
- Take a Taxi
- Drive myself in a Car

**Do All Members have Medical/Health Insurance?**

- Yes
- No

**Did Anyone Serve in the U.S. Military?**

- Yes
- No

**Has SSA or Department of Veteran Affairs Determined Anyone Disabled or Blind?**

- Yes
- No

**Is This a Mixed Immigration Household?**

- Yes
- No
- Refused/Don't Know

**CONSENTS (Required):**

*I give my consent to be contacted by The FoodBank if I am found to be potentially eligible for additional assistance (SNAP, Food Stamps, Free Income Tax Preparation, Affordable Health Insurance, Utilities Assistance, etc.)*

**\* Required**

- Yes  Did Not Give Consent
- 

*I give my consent to be contacted by The FoodBank to share my testimonial and highlight my hunger related experience.\* required*

- Yes  Did Not Give Consent
- 

*I give my consent that my household information and assistance records will be shared through an electronic database, known as "Oasis Insight", with Fulfill. Fulfill is a non-profit organization that helps people identify and obtain assistance to which they may be lawfully entitled. I understand by participating in this database Fulfill may be able to assist me more effectively. I also understand that information provided by me for the Oasis Insight database may be shared with Oasis Insight participating food programs. Any assistance I receive will not be shared with participating food programs. This information may be used to create summary reports for program evaluation purposes.*

*Doy mi consentimiento para compartir la información de mi hogar y mi ayuda a través de una base de datos electrónica conocida como "Oasis Insight", con Fulfill. Fulfill es una organización sin fines de lucro que ayuda a las personas a identificar y obtener la ayuda a la cual pueden legalmente tener derecho.*

*Entiendo que, al participar en esta base de datos, es posible que Fulfill pueda ayudarme más eficazmente. Asimismo, entiendo que la información provista por mí para la base de datos de Oasis Insight puede compartirse con los programas alimenticios participantes de Oasis Insight. Cualquier ayuda que reciba no se compartirá con los programas alimenticios participantes. Esta información puede usarse para crear informes resumidos para fines de evaluación del programa.*

- Yes  No

**\* Required**

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Signature/Firma

**\* Required**

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Date/Fecha