HANNA's Pantry

2024-2025
REGISTRATION FORM

Pantry Use Only

PLACARD: ☐ MEMBER #: _____

DIAPER BANK#: _____

SL ☐ TH ☐ MS ☐ HS ☐ ID VERIFIED (INT) _____

DO YOU LIVE IN SUSQUEHANNA TOWNSHIP? YES ☐ NO ☐ → **DO NOT fill out this form**

PLEASE PRINT CLEARLY BELOW

YOUR NAME: _____ **PHONE:** _____

ADDRESS: _____ **ZIP CODE:** _____ **Can we send you text messages?** Yes ☐ No ☐

Email: _____ **Do you have Internet access?** Yes ☐ No ☐

Do you live in a: House ☐ Apartment ☐ Hotel ☐ Shelter ☐ With a friend/family ☐ Other: _____

How many people live at your address: _____ How many are: 0–17 years: _____ 18–59 years: _____ 60+ years: _____

PRINT THE NAME, BIRTHDAY, AND AGE OF EVERYONE LIVING AT YOUR ADDRESS: *(including you)*

	First Name	Last Name	Birthday *(m/d/y)*	Age	Attends STSD School(s)
1.					☐
2.					☐
3.					☐
4.					☐
5.					☐
6.					☐
7.					☐
8.					☐

Add additional people on the back of the form if needed.

PLEASE CIRCLE ALL LANGUAGES SPOKEN IN YOUR HOME: English नेपाली español اردو ਪੰਜਾਬੀ 中文 हिंदी русский العربية tiếng Việt Kreyòl Ayisyen Bosna ગુજરાતી Other: _____

YOUR RACE: *(this information can help us when we apply for grant funding)*

White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan ☐

6/25/24

FOOD NEEDS

PLEASE CHECK OFF THE FOODS YOU <u>DO NOT</u> EAT:


NO BEEF ☐


NO PORK ☐


NO CHICKEN ☐


NO FISH ☐


NO CANS ☐


NO MILK ☐


NO EGGS ☐


NO CHEESE ☐

We try to accommodate food restrictions based on religious, cultural, and health reasons. Gluten free, low salt/sugar items and other dietary needs may also be available; please ask if they are needed.

PLEASE CHECK IF YOU EAT:

YES ☐

YES ☐

YES ☐

YES ☐

NO FOOD RESTRICTIONS: ☐ Please list any **food allergies**: _____

OTHER NEEDS

1. Would you like to be connected to the **<u>SCHOOL SOCIAL WORKER</u>** for assistance? YES ☐ NO ☐

2. Are you currently receiving **<u>SNAP BENEFITS?</u>***(Supplemental Nutrition Assistance Program)* YES ☐ NO ☐

If no, would like to learn more about getting FREE food through SNAP? YES ☐

3. Are you in need of **ADULT BRIEFS?** YES ☐ NO ☐ **4.** Are you a **VETERAN**? YES ☐ NO ☐

<u>HOW DID YOU FIND OUT ABOUT HANNA's Pantry</u>?

Social Media ☐ Pantry Website ☐ School ☐ Township Newsletter ☐

Digital Sign at the High School ☐ Friend ☐ Central Pennsylvania Food Bank ☐

IF YOU ARE SICK OR CAN NOT ATTEND A DISTRIBUTION

You can give permission for a **PROXY, also known as a substitute or backup person,** to pick up your groceries for you – just list their name below**.** Then if you are not able to attend a distribution, this person can come for you! **Make sure you also list them on the back of the USDA form.**

Proxy Name:_____ **Proxy Signature:** _____ **ID Check Date:**_____

CERTIFICATION STATEMENT AND RELEASE OF LIABILITY

I certify that the information I have provided is correct to the best of my knowledge. I understand that there are no payments or donations required for the food or products I receive. I agree that I will not sell, exchange for property or service anything that I receive from HANNA's Pantry, Inc.

I release HANNA's Pantry, Inc., its employees, volunteers, and donors from any liability resulting from the food and products distributed and agree to hold them harmless against all liabilities, damages, losses, claims, causes of action and suits of law or inequity or obligation whatsoever arising out of or attributed to any actions during the implementation of this food distribution program. HANNA's Pantry, Inc. is an equal opportunity provider.

Your Signature _____ **Date** _____

MEMBER #: _____

DIAPER BANK#: _____

DIAPER BANK#: _____

DIAPER BANK#: _____

2024-2025
DIAPER REGISTRATION FORM

HANNA's Pantry has a partnership with the **Healthy Steps Diaper Bank.** It provides diapers for young pantry children once a month, at no cost to you or HANNA's Pantry.

In order to receive free diapers:

1) The child must be 3 years old or **younger.**
2) The child must live in **your** home.
3) You must provide **ALL the information below** for **EACH** child, as requested by Healthy Steps Diaper Bank.
4) You and your child must be registered as pantry members before diapers can be ordered for your child.
5) **YOU WILL NOT receive diapers the day you fill out this form. You will receive diapers at the next the diaper distribution.**

WHEN YOUR CHILD MOVES TO A NEW DIAPER SIZE, PLEASE LET US KNOW BEFORE THE NEXT DISTRIBUTION OR YOU MAY NOT BE ABLE TO GET THE NEW SIZE. CALL, TEXT, OR EMAIL US. CONTACT INFORMATION IS ALWAYS ON THE NEWSLETTER.

CHILD #1

NAME:_____ **Birthdate** *(m/d/y):* _____ **Diaper Size**: _____ **Weight:** _____

Gender: Male ☐ Female ☐ **Ethnicity**: Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown ☐

Race: American Indian/Alaskan ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐

CHILD #2

NAME:_____ **Birthdate** *(m/d/y):* _____ **Diaper Size**: _____ **Weight:** _____

Gender: Male ☐ Female ☐ **Ethnicity**: Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown ☐

Race: American Indian/Alaskan ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐

If you have more than 2 children, please ask for another form!

OTHER NEEDS

1. Does your child have a documented medical condition that requires diapers YES ☐

2. Are you and your children currently **ENROLLED IN WIC**? *(Women, Infant, Children)* YES ☐ NO ☐

   If no, would you like to learn more about FREE resources through WIC ? YES ☐

Children (0-17) _____

Adults _____

Seniors (60 and up) _____

pennsylvania
DEPARTMENT OF AGRICULTURE

Bureau of Food Assistance

The Emergency Food Assistance Program (TEFAP)

"Self Declaration of Need"

Effective July 1, 2024 to June 30, 2025

Recipient Name	Agency Representative Signature / Date
	HANNA's Pantry #11081
Street Address	Distribution Site Name / Number
	Susquehanna Twp. High School
City State Zip	Distribution Site Location

The Emergency Food Assistance Program is operated in accordance with United States Department of Agriculture (USDA) policy, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. Eligibility is based upon the income guidelines listed below. The recipient circles the entire line that applies to their Household Size, understanding they must be at, or below, the income level indicated to be eligible for program benefits.

Total Household Income (based on 185% of Poverty)

Household Size Circle One	Annual	Monthly	Weekly
1	$ 27,861	$ 2,322	$ 536
2	$ 37,814	$ 3,151	$ 728
3	$ 47,767	$ 3,981	$ 919
4	$ 57,720	$ 4,810	$ 1,110
5	$ 67,673	$ 5,640	$ 1,302
6	$ 77,626	$ 6,469	$ 1,493
7	$ 87,579	$ 7,299	$ 1,685
8	$ 97,532	$ 8,128	$ 1,876
For each additional family member add:	$ 9,953	$ 830	$ 192

I understand the household income limitations and hereby certify that my household size and income make me eligible for participation in the program. I also certify that, as of today, my household lives in the area served by Pennsylvania in The Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of Federal assistance.

I UNDERSTAND THAT MAKING A FALSE STATEMENT MAY RESULT IN MY HAVING TO PAY FOR THE VALUE OF THE FOOD IMPROPERLY ISSUED TO ME AND MAY SUBJECT ME TO CRIMINAL PROSECUTION UNDER STATE AND FEDERAL LAW.

Recipient Signature **Date**

Return completed form to your designated county agency. If you are unsure of the correct agency, please call the Bureau at 1-800-468-2433.

THIS FORM IS NOT TO BE ALTERED OR CHANGED IN ANY WAY.

PLEASE REFER TO THE REVERSE SIDE OF THIS DOCUMENT FOR AN IMPORTANT USDA NON-DISCRIMINATION STATEMENT

USDA Nondiscrimination Statement

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, audiotape, 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

This institution is an equal opportunity provider.

The Emergency Food Assistance Program
Pennsylvania TEFAP Proxy Form

Date _____

I_____ hereby authorize _____ to pick up my TEFAP Food Package and deliver it to me.

_____ _____
Client Signature Proxy Signature

_____ ☐ Proxy ID Verified
Pantry Representative