



# 2023-2024 REGISTRATION FORM

**Pantry Use Only**

PLACARD: MEMBER #: \_\_\_\_\_  
 DIAPER BANK#: \_\_\_\_\_  
 SL  TH  MS  HS  ID VERIFIED (INT) \_\_\_\_\_

**DO YOU LIVE IN  
SUSQUEHANNA TOWNSHIP?** YES  NO



PLEASE PRINT CLEARLY BELOW

**YOUR NAME:** \_\_\_\_\_ **ARE YOU THE HEAD OF THE HOUSEHOLD?** YES  NO   
**ADDRESS:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Internet access?** YES  NO  **Can we send you text messages?** 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:** 0-4 yrs: \_\_\_\_\_ 5-17 yrs: \_\_\_\_\_ 18-59 yrs: \_\_\_\_\_ 60+ yrs: \_\_\_\_\_

**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. _____	_____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	_____	<input type="checkbox"/>
4. _____	_____	_____	_____	<input type="checkbox"/>
5. _____	_____	_____	_____	<input type="checkbox"/>
6. _____	_____	_____	_____	<input type="checkbox"/>
7. _____	_____	_____	_____	<input type="checkbox"/>
8. _____	_____	_____	_____	<input type="checkbox"/>

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

**LANGUAGES SPOKEN IN YOUR HOME:** English  नेपाली  español  اردو  中文  ਪੰਜਾਬੀ   
 हिंदी  русский  Bosna  العربية  tiếng Việt  Kreyòl Ayisyen  ગુજરાતી  Other: \_\_\_\_\_

**RACE:** American Indian/Alaskan  Asian  Black  Native Hawaiian/Pacific Islander  White  Unknown

**ETHNICITY:** Hispanic or Latino  NOT Hispanic or Latino  Unknown

**HOW DID YOU FIND OUT ABOUT HANNA's Pantry?**

Social Media  Website  School  Twp Newsletter  Digital Sign  Friend  Central Pennsylvania Food Bank

# FOOD NEEDS

PLEASE CHECK OFF THE FOODS YOU **DO NOT** EAT:



PLEASE CHECK IF YOU EAT:



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.

**NO** FOOD RESTRICTIONS:

Please list any food allergies: \_\_\_\_\_

# OTHER NEEDS

1. Would you like to be connected to the **SCHOOL SOCIAL WORKER** for assistance? YES  NO

2. Do your children receive a **FREE OR REDUCED SCHOOL LUNCH OR BREAKFAST**? YES  NO   
 If no, would you like to learn more about free school food? YES

3. Are you currently receiving **SNAP BENEFITS?** (*Supplemental Nutrition Assistance Program*) YES  NO   
 If no, would like to learn more about getting free food through SNAP? YES

4. 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

5. When available, how many people in your family can benefit from **WOMEN'S HYGIENE PRODUCTS?**: \_\_\_\_\_

6. If you are in need of **ADULT BRIEFS**, what size? Sm  Medium  Large  XL  XXL

7. Are you a **VETERAN**? YES  NO  Do you belong to a **VFW**? YES  NO

## 8. BACK UP PERSON/"PROXY"

It is recommended that you list a **PROXY**. If you are sick or unable to attend a distribution you can list a person who you will allow to pickup and delivery groceries for you from HANNA's Pantry.

Proxy Name: \_\_\_\_\_ 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 \_\_\_\_\_

# 2023-2024 DIAPER REGISTRATION FORM

MEMBER #: \_\_\_\_\_  
DIAPER BANK#: \_\_\_\_\_  
DIAPER BANK#: \_\_\_\_\_  
DIAPER BANK#: \_\_\_\_\_  
DIAPER BANK#: \_\_\_\_\_

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 HANNA's Pantry. **In order to receive free diapers:**

- 1) the child must live with you in your home
- 2) the child must be 4 years old or younger (once your child turns 5 years old, we can no longer provide diapers)
- 3) and you must provide ALL the information below for **EACH** child:

**In addition: your child must be registered before receiving diapers, so you WILL NOT receive diapers until the next diaper distribution. NOT the day you fill out this form.**

## CHILD #1

**NAME:** Birthdate (m/d/y): Gender: Male  Female  Diaper Size: \_\_\_\_\_  
**Baby Weight:** Toilet/Potty Training: Yes  No   
**Race:** American Indian/Alaskan  Asian  Black  Native Hawaiian/Pacific Islander  White  Unknown   
**Ethnicity:** Hispanic or Latino  NOT Hispanic or Latino  Unknown

## CHILD #2

**NAME:** Birthdate (m/d/y): Gender: Male  Female  Diaper Size: \_\_\_\_\_  
**Baby Weight:** Toilet/Potty Training: Yes  No   
**Race:** American Indian/Alaskan  Asian  Black  Native Hawaiian/Pacific Islander  White  Unknown   
**Ethnicity:** Hispanic or Latino  NOT Hispanic or Latino  Unknown

## CHILD #3

**NAME:** Birthdate (m/d/y): Gender: Male  Female  Diaper Size: \_\_\_\_\_  
**Baby Weight:** Toilet/Potty Training: Yes  No   
**Race:** American Indian/Alaskan  Asian  Black  Native Hawaiian/Pacific Islander  White  Unknown   
**Ethnicity:** Hispanic or Latino  NOT Hispanic or Latino  Unknown

## CHILD #4

**NAME:** Birthdate (m/d/y): Gender: Male  Female  Diaper Size: \_\_\_\_\_  
**Baby Weight:** Toilet/Potty Training: Yes  No   
**Race:** American Indian/Alaskan  Asian  Black  Native Hawaiian/Pacific Islander  White  Unknown   
**Ethnicity:** Hispanic or Latino  NOT Hispanic or Latino  Unknown

Occasionally we receive donated overnight diapers (like Pull-ups). Is that something you use/need? YES   
Is your child 5 years or older and has a medical condition that requires overnight diapers? YES



Children (0-17) \_\_\_\_\_  
 Adults \_\_\_\_\_  
 Seniors (60 and up) \_\_\_\_\_

**Bureau of Food Assistance**

**The Emergency Food Assistance Program (TEFAP)**

**"Self Declaration of Need"**

Effective July 1, 2023 to June 30, 2024

\_\_\_\_\_  
 Recipient Name

\_\_\_\_\_  
 Agency Representative Signature      Date

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 Distribution Site Name      Number

\_\_\_\_\_  
 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.

<b>Total Household Income (based on 185% of Poverty)</b>				
<b>Household Size</b>				
<b>Circle One</b>	<b>Annual</b>		<b>Monthly</b>	<b>Weekly</b>
1	\$ 26,973	\$	2,248	\$ 519
2	\$ 36,482	\$	3,040	\$ 702
3	\$ 45,991	\$	3,833	\$ 884
4	\$ 55,500	\$	4,625	\$ 1,067
5	\$ 65,009	\$	5,417	\$ 1,250
6	\$ 74,518	\$	6,210	\$ 1,433
7	\$ 84,027	\$	7,002	\$ 1,616
8	\$ 93,536	\$	7,795	\$ 1,799
<i>For each additional family member add:</i>	\$ 9,509	\$	792	\$ 183

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 _____	<input type="checkbox"/>
Pantry Representative _____	<input type="checkbox"/> Proxy ID Verified
	Proxy Signature _____