NOTICE

IN ORDER TO QUALIFY FOR ANY RESOURCES WITH THE TOWN OF LEDYARD SOCIAL SERVICE DEPT. YOU WILL NEED TO PROVIDE YEARLY THE FOLLOWING:

1. A valid photo ID
2. Proof of residence in Ledyard/Gales Ferry
3. Rental lease or mortgage statement
4. Four weeks of pay stubs
5. Workers Comp. payments (if applicable)
6. Unemployment payments (if applicable)
7. Social Security Disability payments (if applicable)
8. Pension payments (if applicable)
9. Social Security payments (if applicable)

LEDYARD SOCIAL SERVICES INTAKE FORM

LSS ID# _____

APPLICANT INFORMATION		
Name:	**Veteran: Yes☐ No☐** *(Please check one)*	
Date of birth:	**Home Phone:**	**Cell Phone:**
Email address:		
Current address:		
City:	**State:**	**ZIP Code:**
Own☐ Rent☐ *(Please check one)*	**How long?**	**Household size:**
Marital status:	**Race:**	**Last grade completed in school:**
EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		**Hours per week:**
City:	**State:**	**ZIP Code:**
Position:	**Hourly☐ Salary☐** *(Please check one)*	**Annual income:**
SECOND ADULT (IN HOME) INFORMATION		
Name:	**Veteran: Yes☐ No☐** *(Please check one)*	
Date of birth:	**Cell phone:**	**Email address:**
Marital status:	**Race:**	**Last grade completed in school:**
SECOND ADULT (IN HOME) EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		**Hours per week:**
City:	**State:**	**ZIP Code:**
Position:	**Hourly☐ Salary☐** *(Please check one)*	**Annual income:**

LEDYARD SOCIAL SERVICES INTAKE FORM

LSS ID# _____

INFORMATION FOR CHILDREN RESIDING AT HOME	
CHILD #1: Name:	**Date of birth:** **Age:**
School: **Grade:**	**Health insurance:** **Yes☐ No☐** *(Please check one)*
Relationship to applicant:	**Race:**
CHILD #2: Name:	**Date of birth:** **Age:**
School: **Grade:**	**Health insurance:** **Yes☐ No☐** ***(Please check one)***
Relationship to applicant:	**Race:**
CHILD #3: Name:	**Date of birth:** **Age:**
School: **Grade:**	**Health insurance:** **Yes☐ No☐** ***(Please check one)***
Relationship to applicant:	**Race:**
CHILD #4: Name:	**Date of birth:** **Age:**
School: **Grade:**	**Health insurance:** **Yes☐ No☐** ***(Please check one)***
Relationship to applicant:	**Race:**

ASSISTANCE RECEIVED & MONTHLY AMOUNTS	
SNAP (food stamps): $	**WIC: $**
Free or reduced lunch: $	**Housing Assistance: $**
TANF / SAGA: $	**Child Support: $**
Husky Health Insurance: Yes ☐ No ☐ *(Please check one)*	
MONTHLY EXPENSES	
RENT / MORTGAGE: $	**ELECTRICITY: $**
OIL / GAS: $	**PHONE / CABLE / WIFI: $**
CAR PAYMENT: $	**CAR INSURANCE: $**
CHILD CARE: $	**CHILD SUPPORT / ALIMONY PAYMENTS: $**
FOOD: $	**LOAN PAYMENTS: $**

MONTHLY INCOME SOURCE & MONTHLY AMOUNTS	
Employment: $	**SSI: $**
Pension: $	**Unemployment: $**
Veterans benefits: $	**Worker's Comp.: $**
Alimony: $	

What services can we assist you with?

_____

SIGNATURES	
I authorize the Ledyard Social Services Department to release any/all of the information contained herein to the following agencies: _____ _____ _____	
Applicant's signature:	**Date:**
Town Social Service Representative signature:	**Date:**

RELEASE FROM LIABILITY

I, THE UNDERSIGNED, RELEASE THE TOWN OF LEDYARD AND THE LEDYARD CONGREGATIONAL CHURCH UCC, from any liability resulting from my use of the Town of Ledyard Food Pantry, located and operated by the Ledyard Congregational Church UCC. It is my understanding that the items donated to the food pantry are given in good faith and as such are available at no cost to me to help in meeting my emergency food needs. I further state that I understand that I may freely choose the food items that I consider to be necessary for myself and/or my family. The Town of Ledyard may establish quantity guidelines to ensure that all food items are available to all clients. I further understand that no item or food voucher may be sold or traded and that they are for the private use of my family as designated on my "Intake Form".

_____ _____

Recipient Printed Name Date

_____ _____

Recipient Signature Town Social Services Representative

CT-NAP

(CONNECTICUT NUTRITION ASSISTANCE PROGRAM)

First Name:_____ Last Name:_____

Please indicate the total number of household members that fall into each of the following categories:

AGE			SEX		RACE/ETHNICITY				
Total # Adults Age18-59	Total # Children Age 0-17	Total # Seniors Age 60+	Total # Male	Total # Female	Total # Black	Total # White	Total # Hispanic	Total # Asian Pac. Isl.	Total # Other

W-1700 English
Guidelines Updated as of 07/01/2018

ATTACHMENT 1
235% of poverty

SELF-DECLARATORY FORM

The Emergency Food Assistance Program (TEFAP) Household Eligibility Form	
Name	No. of people in household
Street	No. of Elderly (60+) in household?
Town	No. of Disabled in household
State	No. of Children in household
Tel. ( )	

The table below shows a yearly gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive TEFAP commodities.

Household Size	1	2	3	4	5	6	7	8*
Annual Income	28,529	38,681	48,833	58,985	69,137	79,289	89,441	99,593

- for each additional person add $10,152

You are also eligible to receive TEFAP commodities if your household participates in any of the following programs. If you participate in any one of these programs, please check the box(s) next to it.

- ☐ Food Stamps
- ☐ Energy Assistance
- ☐ WIC
- ☐ School Meals
- ☐ Husky Part A, Part B
- ☐ State Administered General Assistance (SAGA)
- ☐ Temporary Assistance to Needy Families (TANF)
- ☐ Aid to the Blind or Disabled
- ☐ Social Security Supplemental (SSI)
- ☐ Section 8 Rental Assistance Program

Please read the following statement, then sign the form and write in today's date.

I certify that my yearly gross household income is at or below the income listed on this form for households of the same number of people as my household, OR that my household participates in the program that I have checked on this form. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify what I have certified to be true. I understand that making a false certification may result in having to pay the State agency for the value of the food improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. I also certify that, as of today, my household lives in Connecticut.

Signature _____ Today's Date _____