Georgia Department of Human Services
THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)
Household Eligibility Criteria Form

Distribution Agency Site Name: _____

Distribution Agency Site Address: _____

Name of Head of Household: _____

County of Residence: _____ **OR Zip Code:** _____ **Contact Number:** _____
(Optional)

Number in the Household: _____ **Income of the Household:** _____ **Monthly or Weekly** ***(Circle One)***

Household Size	Monthly Income	Weekly Income
1	$2,660	$614
2	$3,608	$833
3	$4,554	$1051
4	$5,500	$1,269
5	$6,448	$1,488
6	$7,394	$1,706
7	$8,340	$1,925
8	$9,288	$2,143
Each additional member	$946	$218

*****This table shows the monthly and weekly income limit 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 food******

Please read: I self-attest that my gross household income ***is at or below the income*** listed for the number of people in my household on this form. I self-attest that I live in the area served by The Emergency Food Assistance Program. This form is being completed in connection with the receipt of federal assistance.

_____ _____
(Signature of Head of Household) **(Date)**

Authorized Representative:

I hereby authorize _____ to pick up food for my household.
(Please print)

_____ _____
(Signature of Head of Household) **(Date)**

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