



**COMMUNITY ACTION
CENTER FOR SELF-RELIANCE
FOOD PANTRIES**

HOUSEHOLD ASSESSMENT 2024

Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____ Date _____

If you wrote Shelburne Falls, what city do you physically live in? Shelburne__ or Buckland__

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Number of people in household: _____

Full Name					
Relationship to HOH	Head of Household				
Date of Birth					
Gender					
Primary Language					
Military Status	Vet Active N/A	Vet Active N/A	Vet Active N/A	Vet Active N/A	Vet Active N/A
Disabled	Yes No	Yes No	Yes No	Yes No	Yes No
Latino or Hispanic	Yes No	Yes No	Yes No	Yes No	Yes No
Race A. White B. Black/African American C. American Indian/Alaskan Native D. Asian E. Native Hawaiian/Other Pacific Islander F. Multi-racial/Biracial G. Other	Choose an option from the list on the left and enter the letter in the box				
Education A. 0-8 th grade B. Some High School C. GED/HiSET D. High School Diploma E. 12+ Some Post-Secondary F. 2 or 4 year college G. Graduate or post-secondary H. Other	Choose an option from the list on the left and enter the letter in the box				
Employment A. Full time B. Part time C. Retired D. Unemployed (3 months) E. Unemployed (6+ months) F. Not in the labor force G. Migrant seasonal farm worker	Choose an option from the list on the left and enter the letter in the box				
Health A. MassHealth (Medicaid) B. Medicare C. HealthConnector D. Employer provided E. Military health care F. Private health insurance	Choose an option from the list on the left and enter the letter in the box				

Current Monthly Income For Your Household

► Please list gross MONTHLY amounts for every member of your financial household listed above

Full Name					
No Income	No income <input type="checkbox"/>	No income <input type="checkbox"/>	No income <input type="checkbox"/>	No income <input type="checkbox"/>	No income <input type="checkbox"/>
Self-employment income	\$	\$	\$	\$	\$
Wages	\$	\$	\$	\$	\$
Unemployment	\$	\$	\$	\$	\$
SSI	\$	\$	\$	\$	\$
SSDI	\$	\$	\$	\$	\$
Social Security Retirement	\$	\$	\$	\$	\$
TAFDC/EAEDC	\$	\$	\$	\$	\$
Child Support	\$	\$	\$	\$	\$
Alimony	\$	\$	\$	\$	\$
VA Benefits	\$	\$	\$	\$	\$
Other Please describe	\$	\$	\$	\$	\$
Total Monthly:	\$	\$	\$	\$	\$

Other Information About Your Household

Benefits (check all that apply)

- Child care voucher
- Fuel Assistance/LIHEAP
- SNAP
- WIC
- Affordable care act subsidy
- Military education support benefit

Housing Type

- Rent or own without subsidy
- Subsidized (housing authority, Section 8)
- Doubled up housing (couch surfing)
- No housing
- Shelter
- Other permanent housing

Family Type

- Single person
- Multigenerational household
- Non-related adults with children
- Single parent
- Two parent
- Two or more adults

Signature

I certify that the information provided is true and accurate to the best of my knowledge.

Signed

Date

Parent or guardian if under 18



Permission to Release Information Community Action Pioneer Valley

Community Action Pioneer Valley (CAPV) wants to offer the best possible programs and services to our community. To help us understand how our programs and services help you, we ask you to provide us with information about you and your family. Information about you and your family is personal and private and it cannot be shared without your written approval.

Your personal information can only be shared in the ways described in this form or as required or allowed by law. Please read it carefully before signing it.

Signing this form gives CAPV staff permission to share your personal information and the personal information for all members of your household that you provide information for, including children, partners, and extended family within CAPV programs and to report your personal information to funders, auditors, or evaluators as may be required. If there is a need for staff to share information about you and your family to other community organizations or service providers, you will sign a separate permission form at that time.

“Personal information” means any information that, because of a name, identifying number, mark or description can be linked with you or a member of your family.

Examples of personal information that may be shared by Community Action Pioneer Valley include:

- Biographic Information (e.g. Name, Date of Birth, Social Security Number)
- Demographic Information (e.g. Race, Ethnicity, Language)
- Program Participation and Eligibility Information
- Information about CAPV's staff's work and contact with you and your family (e.g., caseworker notes or meeting minutes)

What is the purpose of collecting my personal information and how will it be used?

Your personal information, as defined above, is collected and used to:

- Determine what CAPV programs you and your family may be eligible for
- Provide better services to you and your family
- Coordinate and manage services *between programs* at CAPV
- Report to funders, auditors, monitors, evaluators, etc.

Do I have to sign this form?

You do not have to sign this form. But, if you do not, you will not be able to receive services from the following programs: Community Resources & Advocacy, the Center for Self-Reliance Food Pantries and Money Matters. We will refer you to another organization for services.

If I sign, can I take back my permission later?

You are free to take back or cancel your permission regarding the use and sharing of your information (and to stop participation in any program) at any time.

After you tell us that we no longer have your permission, no additional information about your family will be shared, except in cases where the law allows CAPV to continue using your information. If you remove your permission, it does not affect any information that has been shared already. If you choose to remove your permission, you must make this request in writing to the CAPV staff with whom you are working.

Permission to Release Information:

By signing below, I understand that:

- Community Action Pioneer Valley will maintain the privacy of personal and financial information I provide about myself and my family members receiving services from Community Action Pioneer Valley
- Community Action Pioneer Valley may share information among its programs as necessary to provide services to me
- Community Action Pioneer Valley may share information as required by or upon request of government agencies and other entities that fund, regulate, audit, monitor or investigate Community Action Pioneer Valley, and as authorized or required by law, legal process, or court order
- For any other purpose, Community Action Pioneer Valley will ask me before sharing information and get permission from me

Permission to share my personal information is good for up to 1 year after the date that I sign this form.

I hereby certify that the information presented to Community Action Pioneer Valley staff is true and accurate to the best of my knowledge. Misleading or incomplete information may result in denial or termination of services.

Client Name (Please Print): _____

Client Signature: _____

(parent or guardian if under 18)

If under 18, Parent or Guardian Name: _____

Date: _____

For more information about Data Privacy and Confidentiality in CAPV's CMS (CHPM) Database System, visit this link: **[Data Privacy and Confidentiality in CMS \(communityaction.us\)](http://communityaction.us)** or scan this QR code:





USDA/TEFAP DECLARATION OF ELIGIBILITY

*Declaration of financial need is sufficient to receive USDA/TEFAP foods on a guest's first visit. Subsequent visits require declaration of eligibility according to the guidelines below. Guests must be allowed to self-declare eligibility. Verification of residence, income, or receipt of benefits is not required. **Photo ID and Social Security numbers are not required**, and requesting this information is prohibited by USDA and the Commonwealth of Massachusetts. Declaration of Eligibility must be kept on file for each guest for the current fiscal year plus three previous years. Programs must track each time guests receive USDA, but the guest is not required to sign or recertify eligibility after initial declaration. Although not required, best practice is to recertify eligibility annually.*

Name: _____

Town of Residence: _____

Number of people in household: _____

Do you receive any of the following types of assistance? Please check all that apply:

WIC: _____ TANF: _____ SSI: _____ Fuel Assistance: _____ SNAP: _____ Veteran's Aid: _____

Head Start: _____ AFDC: _____ Medicaid (MassHealth): _____ Free/Reduced-Price School Lunch _____ EAEDC: _____

If you do NOT receive any of the types of assistance listed above, does your household income meet the following

income guidelines*? Please circle: YES NO

<i># of Household Members</i>	<i>Annual</i>	<i>Monthly</i>	<i>Weekly</i>
1	36,450	3,038	701
2	49,300	4,108	948
3	62,150	5,179	1,195
4	75,000	6,250	1,442
5	87,850	7,321	1,689
6	100,700	8,392	1,937
7	113,550	9,463	2,184
8	126,400	10,553	2,431
For each additional household member, add:	+12,850	+1,071	+247

TEFAP Income Guidelines 2023-2024

If guest does NOT receive any of the above benefits OR meet income guidelines, the guest may declare financial need to receive USDA/TEFAP foods on their first visit ONLY. Eligibility according to above requirements must be certified at subsequent visits.

Check HERE to declare financial need:

Client Signature: _____

Date: _____

This institution is an equal opportunity provider and employer.

THIS PAGE IS FOR STAFF ONLY

Staff: Circle HH size and Income level in below table. For income, circle the 2 levels the income falls between:

Household Size	1	2	3	4	5	6	7	8
200% of federal poverty level (CSBG) Monthly:	\$ 2,430	\$ 3,287	\$ 4,166	\$ 5,000	\$ 5,857	\$ 6,713	\$ 7,570	\$ 8,425
*effective 1/12/2023 Annual:	\$29,160	\$39,440	\$49,991	\$60,000	\$70,280	\$80,560	\$90,840	\$101,120
250% of federal poverty level (COVID USDA) Monthly:	\$ 3,038	\$ 4,108	\$ 5,179	\$ 6,250	\$ 7,321	\$ 8,392	\$ 9,463	\$ 10,553
*effective 1/12/2023 Annual:	\$36,450	\$49,300	\$62,150	\$75,00	\$87,850	\$100,700	\$113,550	\$126,400
30% of median income (extremely low) Monthly:	\$ 1,745	\$ 1,995	\$ 2,245	\$ 2,491	\$ 2,691	\$ 2,891	\$ 3,091	\$ 3,291
*effective 6/15/23 Annual:	\$20,950	\$23,950	\$26,950	\$29,900	\$32,300	\$34,700	\$37,100	\$39,500
50% of median income (very low) Monthly:	\$ 2,908	\$ 3,320	\$ 3,737	\$ 4,150	\$ 4,483	\$ 4,816	\$ 5,150	\$ 5,479
*effective 6/15/23 Annual:	\$34,900	\$39,850	\$44,850	\$49,800	\$53,800	\$57,800	\$61,800	\$65,750
80% of median income (low) Monthly:	\$ 4,650	\$ 5,316	\$ 5,979	\$ 6,641	\$ 7,175	\$ 7,708	\$ 8,237	\$ 8,770
*effective 6/15/23 Annual:	\$55,800	\$63,800	\$71,750	\$79,700	\$86,100	\$92,500	\$98,850	\$105,250

Enrollment Application Complete: Staff Name: _____ Staff Signature: _____ Date: _____

Enrollment Application Incomplete: Staff Name: _____ Staff Signature: _____ Date: _____

Notes: