

Proxy Consent Form

Please Complete (TEFAP) Emergency Food Assistance Program Beneficiary Information Below

Beneficiary Name _____
Address _____
City and Zip Code _____
Phone Number _____

I hereby designate: _____ (Name of Proxy)
First Last

To serve as my proxy to sign required documents, and pick-up my food benefits from the following agency:

Name of Agency City

I understand that I take full responsibility for the actions of my proxy. I will inform him or her of the proper procedures when acting on my behalf. My signature declares my continued eligibility for food benefits.

Beneficiary Signature Date

Proxy Signature Date

Agency Use Only - Approved By:

Print Name

Signature

Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. Send your completed form or letter to us by mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights; 1400 Independence Avenue, SW; Washington, D.C. 20250-9410. By fax: (202) 690-7442 or email at program.intake@usda.gov.

This Institution is an Equal Opportunity Provider

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Division of Children and Family Services

The Emergency Food Assistance Program**(TEFAP) Eligibility to Take Food Home**

I, the undersigned, agree to indemnify and hold harmless this Agent and the State of Nebraska, their Departments, officers, agencies, and employees, from any and all claims, demands, damages costs, expenses, actions, and causes of action out of any act or occurrence pertaining to the issuance and acceptance of the USDA donated food items.

I further certify that my household's current gross income is equal to or below the Current Monthly Income amounts, or that I am participating in one of the following: SNAP, ADC, State Supplemental (AABD), Energy, Medical only, State Disability, or Refugee Program.

Size of Household	Current Monthly Income	Size of Household	Current Monthly Income	For each additional household member Add \$681
1	\$ 1,932	5	\$ 4,656	
2	\$ 2,613	6	\$ 5,337	
3	\$ 3,294	7	\$ 6,018	
4	\$ 3,975	8	\$ 6,699	

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Signature	Address	No. in Household	Month	Year

FDP-105 Rev. 03/11/2021(54004)