

**The Emergency Food Assistance Program (TEFAP)**  
**Household Eligibility Criteria Form**

Distribution Date: \_\_\_\_\_

Distribution Site: \_\_\_\_\_

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

Address: \_\_\_\_\_

Number of people in household: \_\_\_\_\_

\_\_\_\_\_

County: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**This table shows monthly and weekly 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 food.**

Household Size	Monthly Income	Weekly Income
1	\$1,316	\$304
2	\$1,784	\$412
3	\$2,252	\$520
4	\$2,720	\$628
5	\$3,188	\$736
6	\$3,656	\$843
7	\$4,124	\$952
8	\$4,592	\$1,060
Each additional member	Add \$468	Add \$120

I certify that my gross household income is at or below the income listed on this form for households that live in the area served by the Georgia Emergency Food Assistance Program. This certification form is being completed in connection with the receipt of federal assistance.

\_\_\_\_\_  
 (Signature of Head of Household)

\_\_\_\_\_  
 (Date)

**Authorized Representative:**

I hereby authorize \_\_\_\_\_  
 (Please Print)

to pick up food for my household.

\_\_\_\_\_  
 (Signature of Head of Household)

\_\_\_\_\_  
 (Date)

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