Cambridge Home Delivery Program

1. Please call each household and, using the criteria below, determine if they are eligible. If so, please complete the included application.

2. For households qualifying for a reason other than age, they will require a referral letter from a health care provider (doctor, nurse, physician assistant, etc.) ON THAT PROVIDER’S STATIONERY. The letter should state that, “Due to physical or other impairments, (client name) is unable to use an existing Food Pantry.” An appropriate explanation of impairment(s) must be included as well as the name of the contact person and the phone number of this provider. Please see/utilize the letter template included in this application packet. (All letters will be followed up and confirmed).
WHAT WE DO:

Twice a month, we will deliver groceries (30 - 40 pounds), including:

- Fresh produce such as: bananas, oranges, collard greens, onions, potatoes...Produce depends greatly on available stock
- Variety of non-perishables such as: peanut butter, tuna fish, cereal, pasta, canned soups... Dry goods also depend on stock available

We cannot accommodate any dietary restrictions or special requests.

- We deliver 2 weekends every month.
- We will give each client a list of the year’s delivery dates. It is then the client’s responsibility to inform the Home Delivery Coordinator if they will not be home for a delivery
- CLIENTS MUST BE HOME TO RECEIVE AND SIGN FOR DELIVERIES. NO RESCHEDULING WILL BE DONE FOR UNDELIVERABLE ITEMS.

WHO QUALIFIES:

This program exists for people who don’t have other options to get food. If they can afford to buy food, they should be ordering delivery. If someone in their household (or a friend or relative) can go to a food pantry on their behalf, they should get food that way. Unless they are qualifying because of age (over 60), they will be required to provide a doctor’s note explaining why they need this service (example at bottom of document).

To qualify the resident must validate that:

1. Everyone in their household either:
   - Has difficulty accessing food pantries because of disability, impairment or
   - extreme vulnerability to covid-19 due to age (60+), or underlying condition
   - or
   - Is under age 18
2. They do not have a nearby friend or relation that can go to a food pantry/grocery store on their behalf

3. They meet the following income requirements
   
   1 household member: Less than $41,500
   2 household members: Less than $47,400
   3 household members: Less than $53,350

IF THE INDIVIDUAL MEETS ALL THE ABOVE REQUIREMENTS, THEN PLEASE PROCEED TO FILL OUT THE BELOW APPLICATION
Food For Free Committee --- Home Delivery Application 2020

Our agency receives Community Development Block Grant (CDBG) funding from the Federal Housing and Urban Development Department (HUD). They require that we obtain the following information. This information is collected for statistical reasons only and is kept in strict confidence. Please help us by filling in the information on this form.

FIRST NAME: _______________________________________
LAST NAME: _______________________________________

PHONE NUMBER: ________________________________ DATE OF BIRTH: _______________ AGE: __________

STREET #: ______________________ STREET NAME: ____________________________________

APARTMENT #: ___________________ ZIP CODE ________________

ALTERNATE CONTACT (Name & Phone Number): _______________________________________________________ 

1a. Total number of members in your household: ____________

1b. Total number of children under the age of 18 in your household: ____________

2. Please check the category in which the combined gross annual income of your household falls:

<table>
<thead>
<tr>
<th># OF MEMBERS IN HOUSEHOLD</th>
<th>LOW INCOME</th>
<th>LOW/MODERATE INCOME</th>
<th>ABOVE MODERATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-member</td>
<td>Less than $41,500</td>
<td>$41,501—$49,800</td>
<td>$49,800+</td>
</tr>
<tr>
<td>2-members</td>
<td>Less than $47,400</td>
<td>$47,401—$56,880</td>
<td>$56,880+</td>
</tr>
<tr>
<td>3-members</td>
<td>Less than $53,350</td>
<td>$53,351—$64,020</td>
<td>$64,020+</td>
</tr>
</tbody>
</table>

3. In order to receive funding from the USDA’s Emergency Food Assistance Program (TEFAP) we are required to obtain the following information. Please check the box below if you qualify in the Annual Income category, and/or if you receive any of the following services:

<table>
<thead>
<tr>
<th>Annual Income less than $23,107</th>
<th>Supplemental Security Income</th>
<th>Fuel Assistance</th>
<th>SNAP</th>
<th>AFDC</th>
<th>Veteran’s Aid</th>
<th>(WIC)</th>
<th>Welfare</th>
<th>Medicaid</th>
</tr>
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4. PRIMARY LANGUAGE: ________________________________
5. RACE/ETHNICITY – each client is required to complete both the “Ethnicity” and the “Race” boxes:

<table>
<thead>
<tr>
<th>ETHNICITY (please select one):</th>
<th>______ Hispanic or Latino</th>
<th>______ Not Hispanic or Latino</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RACE (please select one):</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>_____ American Indian or Alaska Native</td>
<td>_____ Black or African American</td>
<td></td>
</tr>
<tr>
<td>_____ American Indian/Alaska Native &amp; Black/African American</td>
<td>_____ Black/African American &amp; White</td>
<td></td>
</tr>
<tr>
<td>_____ American Indian/Alaska Native &amp; White</td>
<td>_____ Native Hawaiian or Other Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>_____ Asian</td>
<td>_____ White</td>
<td></td>
</tr>
<tr>
<td>_____ Asian/White</td>
<td>_____ Other Multi-Racial (not listed above)</td>
<td></td>
</tr>
</tbody>
</table>

6. MISCELLANEOUS (please check): _____ Female Head of Household  _____ 62 years of age or older  
   _____ Person with disability

7. How often do you currently skip meals? Please check one box:
   - [ ] Every day
   - [ ] At least once a week
   - [ ] 2 to 3 times a month
   - [ ] Once a month
   - [ ] Never

8. How often do you currently choose between buying food and paying for bills, rent, or medication because you don’t have enough money? Please check one box:
   - [ ] Every month
   - [ ] Every 2 or 3 months
   - [ ] Once a year
   - [ ] Never

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

   Client Representative _______________________________ Date ________________

   Email ____________________________________ Phone Number ____________________________
To whom it may concern:

Due to physical or other impairments, ____________________________ is unable to use an existing Food Pantry. These impairments include the following:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I, the undersigned, request that this patient receive delivery of food twice monthly as part of the Food For Free Home Delivery program.

Sincerely,