FOOD PANTRY APPLICATION
HILLSBOROUGH TOWNSHIP

379 SOUTH BRANCH ROAD
HILLSBOROUGH, NEW JERSEY 08844
(908) 369-3880

The information on this application form is completely confidential.

(OFFICE USE) (w-2020)
DATE:__________
❑ Interviewed by__________
❑ Residency verified
❑ Income verified
❑ Approved

Name: __________ **DATE OF BIRTH:** __________ **Spouse/ Partner :** __________ **DATE OF BIRTH:** __________

Street Address: __________ **Apt #** __________ **Phone #'S :** Cell: House:

How did you hear about the Food Pantry: __________

Is your difficulty in obtaining food **Temporary :** ❑ **Permanent:** ❑

*********LIST ALL INDIVIDUALS LIVING IN YOUR HOME WITH YOU (INCLUDE NAME, AGE AND RELATIONSHIP):*********

Name:	Date of Birth	Relationship	Name:	Date of Birth	Relationship
1.			4.		
2.			5.		
3.			6.		

List the names of any individuals in the home who receive any type of income:

Name:	Amount:	Source: Include Alimony/Child Support	Name:	Amount:	Source: Include Alimony/Child Support
1.			4.		
2.			5.		
3.			6.		

Total Monthly Income After Taxes: __________

Do you receive SNAP assistance? YES ❑ NO ❑
If so how much per month: $__________

Are you receiving assistance with your utility bills? YES ❑ NO ❑
If so how much per month: $__________ from who?__________

List all agencies that are providing you assistance: __________

Living situation: **Rent:** ❑ **Own:** ❑ **Staying with Family:** ❑ **Apartment:** ❑ **Condo/Townhouse:** ❑ **Home:** ❑

Is your home purchased/rented thru Affordable Housing? YES ❑ NO ❑
If so which type Section 8 ❑ Low ❑ Moderate ❑

Monthly Expenses (please fill in dollar amounts): $ __________ **Rent /Mortgage :** $ __________

Do you receive rental assistance? YES ❑ NO ❑ If so how much? $ __________

Gas: $ __________ **Electric:** $ __________ **Phone:** $ __________ **Cable:** $ __________ **Other:** $ __________

Car Insurance : $ __________ **Car Pmt :** $ __________ **Credit Cards :** $ __________ **Medical :** $ __________

In as much detail as possible, please tell us why you are experiencing financial difficulty:

____

____

____

____

____

What plans do you have to change your financial situation? Please be as specific as possible:

____

____

____

Do you have health insurance? YES ☐ NO ☐ **Do you have insurance for prescriptions?** YES ☐ NO ☐

Have you been to Somerset County Social Services yet? YES ☐ NO ☐

Any person who applies for or receives CAN benefits for which they are not eligible, by having intentionally made a false or misleading statement or concealed or withheld facts, shall be subject to the following penalties.

The foregoing violations can result in the individual being ineligible for receipt or further receipt of CAN program benefits as follows:

First violation – 6 months, Second violation – 12 months, Third violation – permanent disqualification

In addition, the remaining household members for which CAN benefits may have been eligible shall also be ineligible for benefits.

Release Statements

I (we) hereby authorize the Hillsborough Township Department of Social Services to contact any individual or other source who may have knowledge about my (our) circumstances for the sole purpose of verifying the statements I (we) have made.

I (we) hereby authorize any banking institution or social service agency to release any information requested by the Hillsborough Township Department of Social Services.

______________________________ ______________________________

Applicant's name (Printed) **Applicant's signature** **Date**

______________________________ ______________________________

Applicant's name (Printed) **Applicant's signature** **Date**

(office use only) (Check off items attached)

Photo ID Provided ☐ **Proof of Residency - Lease or Rental Agreement** ☐ **Tax Bill** ☐ **Mortgage Document** ☐

Copy of Federal Income Tax Return (note year) ________☐ **SSI/D Statement**☐ **W2's**☐ **Paystubs**☐ ________☐