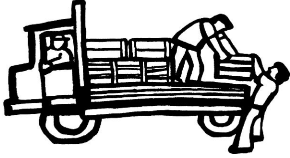


Food For Free
11 Inman Street
Cambridge, MA 02139
Phone 617-868-2900
Fax 617-868-2395
www.foodforfree.org

HOW TO APPLY:

To apply, return the following items to:

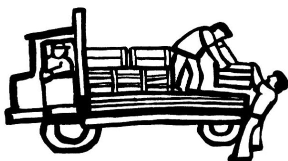
Food For Free
11 Inman Street
Cambridge, MA 02139

1. A completed and signed application form **with a phone number where you can be reached.**

2. 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, (*your 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*).

If you have any questions, please contact:

Home Delivery Coordinator
Food For Free Committee, Inc.
617-868-2900, ext. 326
homedelivery@foodforfree.org



FOOD FOR FREE

Cambridge Home Delivery Program

WHAT WE DO:

Twice a month, we will deliver *one box* of groceries, including:

- Fresh produce such as: bananas, oranges, collard greens, onions, potatoes…
- Variety of non-perishables such as: peanut butter, tuna fish, cereal, pasta, canned soups…

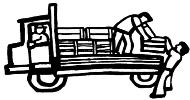
WHO WE SERVE:

We serve CAMBRIDGE residents who:

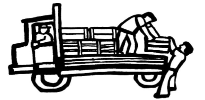
- **Live alone.**
- Earn less than $34,350 per year.
- Have difficulty accessing Food Pantries in Cambridge, because of disability or impairment.

HOW IT WORKS:

- We deliver on the 2nd Friday, Saturday or Sunday *and* the 4th Friday, Saturday or Sunday of every month. Currently, we are only signing up new clients for Saturday and Sunday deliveries.
- 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.



Food For Free Committee --- Home Delivery Application 2017



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. If you have any questions, our staff will be glad to help you.

(please print)

FIRST NAME: ____ **LAST NAME:** __________________________________

STREET ADDRESS: ___________________________________ **PHONE NUMBER:**______________________________

ALTERNATE CONTACT(Name & Phone Number): ____

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

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

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

# OF MEMBERS IN HOUSEHOLD	LOW INCOME	LOW/MODERATE INCOME	ABOVE MODERATE
1-member	Less than $34,350 ______	$34,350-$51,500 ______	$51,500+ ______
2-members	Less than $39,250 ______	$39,250-$58,450 ______	$58,450+ ______
3-members	Less than $44,150 ______	$44,150-$65,750 ______	$65,750+ ______

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:

Annual Income less than $22,311	Supplemental Security Income	Fuel Assistance	SNAP	AFDC	Veteran's Aid	(WIC)	Welfare	Medicaid
☐	☐	☐	☐	☐	☐	☐	☐	☐

4. RACE/ETHNICITY – each client is required to complete both the "Ethnicity" and the "Race" boxes:

ETHNICITY *(please select one)*: ______ ***Hispanic or Latino*** _______ ***Not Hispanic or Latino***

RACE *(please select one)*:

____American Indian or Alaska Native

____American Indian/Alaska Native & Black/African American

____American Indian/Alaska Native & White

____Asian

____Asian/White

____Black or African American

____Black/African American & White

____Native Hawaiian or Other Pacific Islander

____White

____Other Multi-Racial *(not listed above)*

5. PRIMARY LANGUAGE: ____

6. MISCELLANEOUS (*please check*):______Female Head of Household______62 years of age or older ______Person with disability

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

______________________________ ______________________

Client Signature **Date**

To whom it may concern:

Due to physical or other impairments, ______________________________ is unable to use
patient name

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,

This letter must be printed on the health care provider's stationary and returned to Food For Free, 11 Inman St., Cambridge, MA 02139.
Fax: 617-868-2395 Email: homedelivery@foodforfree.org
If you have any questions, please call the Home Delivery Coordinator: 617-868-2900, ext. 326.