Senior Supplement Distribution Form

Once a year fill in the top portion of this form. Have each participant sign each month they receive a box.

Name _____
Last **First** **Middle Initial**

Address _____

_____ **County** _____

Gender _____ **Phone #** _____ **Number in Family** _____
(M or F)

Eligibility Criteria (please check all that apply)

- ☐ Proof of eligibility to receive food stamps
- ☐ Proof of eligibility for aid to families with dependent children (AFDC)
- ☐ Proof of eligibility to receive supplemental security income (SSI)
- ☐ Signed, self-declaration showing that the household income falls below 130% of the poverty level.
- ☐ Other special circumstances _____

Special dietary needs: Diabetes ____ Hypertension ____ Vegetarian ____ Other ____

YEAR OF DISTRIBUTION _____

MONTH OF DISTRIBUTION	DATE RECEIVED	CLIENT SIGNATURE
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Montgomery Area Food Bank is an equal opportunity employer and provider.