

# EMERGENCY FOOD ASSISTANCE PROGRAM (EFAP)

## APPLICATION

**Please print all information. If you have more than one type of program, submit a separate application for each. Failure to return application within 15 business days will result in voiding your request for EFAP membership.**

Program Type (check one only)  SK (Soup Kitchen)  FP (Food Pantry)

Name of Submitting Organization \_\_\_\_\_

Submitting Organization Type  Religious Organization  Nonprofit Agency  Other \_\_\_\_\_

- **Attach a list of the Board of Directors.**

Employer I.D. Number (EIN)

- **Attach IRS verification of submitting/applicant organization's Federal Taxpayer I.D. Number (EIN) listed above, and Federal Tax Exempt Status [501(c)(3)]. If using parent organization's 501(c)(3), submit letter authorizing use, and a copy of relationship agreement or other document of sponsorship (please highlight your program listing). If you do not have this information, do not proceed. Do not submit the application without verification.**

Food Program Name \_\_\_\_\_

- **This is the name of your soup kitchen or food pantry, if different from the submitting organization name.**

• Community District where Food Program is located

Food Program Address \_\_\_\_\_  
Boro Zip

Mailing Address \_\_\_\_\_  
• **If different from program address.**

Distribution Site Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

EMAIL Address \_\_\_\_\_

- **Your organization must serve the general public, not just the residents, clients, or members of your organization's facility/program. If your organization does not serve the general public, do not proceed with the application. You are not eligible for participation in EFAP.**

**CURRENT PROGRAM INFORMATION**

Which program areas best describe other services, if any, provided by your organization? Check all that apply.

- *Attach brochure or other public information material if available .*

<b>Program Areas</b>	
SNAP Outreach	
Information & Referral/Benefit Counseling/Advocacy	
Alcohol/Substance Abuse Treatment Program	
Drop-In Center	
Temporary Shelter (0-6 months)	
Transitional Shelter (6-18 months, includes Tier II)	
Supportive Housing/Residence (long-term/permanent)	
AIDS Prevention/Support Services (community-based)	
Adult Day Care Program	
Day Treatment Center	
Day Care Center	
After School Program	
Child Abuse Prevention Program	
Senior Center/Meals On Wheels to Seniors	
Eviction Prevention Program	
Employment Preparation/Placement	
Counseling	
Other (Describe):	

1. Describe your current emergency food program, the community you serve, and the surrounding area.

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2. Do you service a special needs population? Describe.

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3. Travel Directions – (ex.: Take the Q4 bus to Linden Blvd & Farmers Blvd. Located on the corner of 117<sup>th</sup> Road or Take the J or M train to Broadway & Myrtle Avenue. Located between Myrtle Avenue & Evergreen Avenue)

Take the \_\_\_\_\_

Site is located (between or near) \_\_\_\_\_

4. Food funding sources. Check all that are currently received by your program.

- **Attach documentation of sources such as membership agreement, award letter, or organization budget letter.**

<input type="checkbox"/> HPNAP – United Way	<input type="checkbox"/> Food Bank for New York City
<input type="checkbox"/> EFSP – United Way	<input type="checkbox"/> HPNAP – Food Bank for New York City
<input type="checkbox"/> EFSP – Independent	<input type="checkbox"/> TEFAP – Food Bank
<input type="checkbox"/> City Harvest	<input type="checkbox"/> Foundation/private grants (specify) _____
<input type="checkbox"/> Organization Budget (specify) _____	<input type="checkbox"/> Private sector donations (specify) _____
<input type="checkbox"/> Other (specify): _____	

If you have been assigned a program ID # or Tag # from any agency listed above, please indicate.

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5. Staff Type (fill in how many)      Paid       Volunteer

- **Attach a list of volunteer job descriptions.**

6. When did you start your food program?       Month       Year

7. Program days and hours of operation when serving or distributing food.

<input type="checkbox"/> Mon. _____	<input type="checkbox"/> Tues. _____	<input type="checkbox"/> Wed. _____	<input type="checkbox"/> Thurs. _____
<input type="checkbox"/> Fri. _____	<input type="checkbox"/> Sat. _____	<input type="checkbox"/> Sun. _____	

8. What are your office hours?

<input type="checkbox"/> Mon. _____	<input type="checkbox"/> Tues. _____	<input type="checkbox"/> Wed. _____	<input type="checkbox"/> Thurs. _____
<input type="checkbox"/> Fri. _____	<input type="checkbox"/> Sat. _____	<input type="checkbox"/> Sun. _____	

9. Is your soup kitchen or food pantry closed anytime during the year?       Yes       No

If "Yes", when? \_\_\_\_\_

10. Is your soup kitchen or food pantry accessible to the physically challenged?       Yes       No

If "Yes", describe how you accommodate this population. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. How does your food program keep a record of the number of people – children, adults, and seniors, you serve? Describe.

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12. How many people did your food program service in the last 3 months?

- **Attach copy of most recent monthly report.**

Children	Adults	Seniors
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you limit the number of times a participant may use the program?  Yes  No

If "Yes", explain \_\_\_\_\_

13. Meal Type Served  On-Site Prepared Meal  Food Package for Home Consumption

Other. Describe. \_\_\_\_\_

14. **Soup Kitchen Only** (Complete only if you operate a Soup Kitchen)

- **Attach copy of Department of Health Permit. Do not submit the application without the permit.**

Check all that apply. Meal served  Breakfast  Lunch  Dinner

15. **Food Pantry Only** (Complete only if you operate a Food Pantry)

Number of days an average food package serves:  One  Two  Three  Four or more  
Number of meals per day provided in an average package:  One  Two  Three

16. Please give a description of the area where your food is stored and its location. \_\_\_\_\_

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17. Is storage space locked and secured?  Yes  No

18. Are all products stored in the designated area on appropriate racks at least 6" from the floor or wall?  Yes  No

19. Do you have any problem storing garbage between pick-ups?  Yes  No

20. Does a licensed exterminator come to the site on a regular basis?  Yes  No

If "Yes", how often?  Yearly  Quarterly  Monthly  Bi-weekly  Weekly  Daily

- **Attach copy of contract or exterminating schedule.**

If "No", describe measures taken to keep space free of vermin. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact person (please print) \_\_\_\_\_

Contact person signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized by (please print) \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return original application and supporting documents to:**

**NYC Human Resources Administration  
Emergency Food & Nutrition Assistance Program  
150 Greenwich Street – 43<sup>rd</sup> Floor  
New York, New York 10007  
(929) 221-7679**

04/27/15