A GREATER HARVEST APPLICATION

Food Pantry Plus

P.O. Box 4118 • Newark, NJ 07112 • (973) 318-7337

Ticket #

INTAKE NUMBER: _____

APPL. STATUS [P] (A) Approved (D) Denied (P) Pending

Distribution Code: _____

PLEASE PRINT CLEARLY AND FILL IN ALL OF THE INFORMATION REQUESTED IN THE SPACES PROVIDED.
IF YOU SKIP ANY PART OF THIS APPLICATION IT WILL BE CONSIDERED INCOMPLETE AND MAY CAUSE A DELAY.

Name: _____ Sex: [ ]
(Last) (First) (MI) (M or F)

Address: _____
(Apt/Suite/Floor)

City/State/Zip Code: _____ NJ

Contact Info: _____
(Home) (Cellphone) (Email Address)

HOUSEHOLD SIZE

Adults _____ Children _____ Pets _____

18-30	_____	Newborn	_____ Girl Boy	Cats	_____
31-50	_____	1-5	_____ Girl Boy	Dogs	_____
51-61	_____	6-12	_____	Other	_____
Senior (62 & Over)	_____	13-17	_____		

Check one

DISCLAIMER

Notice: Hold Harmless Agreement

By placing my initials in the box below, I authorize A GreatER Harvest to use any pictures and testimonies concerning me to further promote this organization. [ ]

Please understand that A GreatER Harvest is a nonprofit, referral service, which is simply acting as intermediary between sponsoring families, donors, and families seeking assistance. As a result, we disclaim all liability which may result from the consumption of food, or use of any donated item provided as a result of this application. This disclaimer includes, but is not limited to any sickness, injury or death that may result from the receipt of goods, food, or consumption of contaminated food, spoiled food, or tainted food, or other injury or death caused by the acts of the sponsor.

I have read the above Hold Harmless Agreement in its entirety and fully understand the same. I hereby agree to hold A GreatER Harvest, its Officers, Director, Staff & Volunteers harmless from injury, illness of death that may result from the receipt, use, and/or consumption of the goods and food provided to me as a result of this application. In addition to injury or death resulting from any acts of the sponsor.

RENEWAL [ ]

Signature: _____ Date: _____

FOR OFFICE & STAFF USE ONLY

PROOF OF:

Identification	Address	Children	Low Income	Disaster
[ ]	[ ]	[ ]	[ ]	[ ]

Food Stamps	WIC	TANIF	Medicaid	SSI / SSD / SS
[ ]	[ ]	[ ]	[ ]	[ ]

Supplemental Nutrition Assistance Program:

[ ] Ran out/Insufficient [ ] Lost [ ] Stolen [ ] Not Received

Special Diets/Needs: _____

How did you hear about AGH? _____

Notes: _____

Intake Specialist: _____

Comments: _____

Reviewer: _____

REFERRAL

Organization Referral Id: _____

(Revised 3/16/12)