

Approved:
Comments:YesNoDate:Initials:

APPLICATION FOR MEMBERSHIP

Does your agency have a 501(c) (3) letter of determination from the IRS? () Yes () No

GENERAL INFORMATION

Agency Name:					
Site Address:					
Street Address		City	State	Zip	County
Mailing Address:		<u> </u>	0	7	
Address		City	State	Zip	
Phone Number:		Fax Numb	er:		
Contact Name and Title:					
E-mail address:					
Executive Director/Pastor (if diffe	erent than above	e):			
Is your organization an affiliate o	f another organ	ization? () Ye	s () No		
If yes, name of parent organization Parent organization is proposed of your program.			ly responsible for th	ne operation	and liabilities
Sources of Funding:					
Donations%	Grants/Foundati	ions%	Fundraising Even	ts%	
Other% Please exp	olain:				
Date current food program began Monthly food budget:					
Number of Volunteers involved in	n program(s):				
Source of food: %Purchased	%	Donated			
Please list retail/wholesale food s	uppliers:				
Are you a distributer for Angel For If yes, which one?				() Yes	() No

SERVICE INFORMATION

Geographic service boundaries (if any):				
Client restrictions (if any):				
How does your organization screen clients for eligibility?				
Describe your intake process, and attach sample screening/intake forms:				
Does your organization require income verification and/or client identification? Please explain:				
Describe your record-keeping system:				
Do you charge a fee or require clients to work or volunteer for services? () Yes () No If yes, describe fee/work requirement system:				
Do you have adequate transportation to pick up product from Food Bank? () Yes () No Do you have regular pest control? If <i>Yes</i> , please provide company name:				
PANTRY PROGRAMS (Complete if your agency distributes bags/boxes of food)				
Days/Hours of Operation:				
How many households are served: Daily WeeklyMonthly				
How many total individuals in the above households: Daily WeeklyMonthly				
How many days worth of food do you provide?				
Is your pantry open for emergencies? () Yes () No If yes, number to call:				
How often may clients receive food?				

ON-SITE MEAL PROVIDERS

(Complete if clients eat meals or snacks at your location)

Days/Hours of Op	eration:			
What type of progr	ram (kitchen, shelter, re	ehab etc.)?		
How many meals a	are served:			
Breakfast:	Daily	_Weekly	Monthly	
Lunch:	Daily	_Weekly	Monthly	
Snacks:	Daily	_Weekly	Monthly	
Dinner:	Daily	_Weekly	Monthly	
Does your agency	prepare meals on site?	() Yes () N	lo Use catered	meals? ()Yes ()No
Is your agency lice	ensed and inspected by	the Board of Hea	lth? () Yes () No	0
If yes, what is you	r license number?			
Describe kitchen f	acility:			
STORAGE A	REA			
La storage eres cas	ure and looked? ()	Vac	() No	
-	ure and locked? ()		() No	
Describe dry stora	ge area (size, shelves, c	abinets, pallets, t	asement area, etc):	
Indicate how many	v refrigerators and freez	zers your agency l	nas:	
Residential refrigerators				
Commercial (reach-in or walk-in) refrigerators				
Chest freezers				
Upright freezers				
Commercial (reach-in or walk-in) freezers				
	nometers in: () Dry state temperature logs?		() Refrigerators() No	() Freezers

agencies not meeting our criteria.

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1. Name:	Phone:	
2. Name:	Phone:	
Authorized people to pick up food orders at the Food Bar	nk (if different):	
1. Name:	_ Phone:	
2. Name:	_ Phone:	
To the best of my knowledge the above information is correct.		
Application completed by (please print)		Date
Signature of Agency Director		Date

Please Note: completion of this application does not guarantee membership. We reserve the right to refuse membership to

Authorized people to **place food orders** at the Food Bank: