The Emergency Food Assistance Program (TEFAP) and Commodity Supplemental Food Program (CSFP) – Referral Request

Name of Partner Charity: _____

Contact Information for Program Staff:

Name: _____

Phone Number: _____

Email Address: _____

If you object to receiving services from us based on the religious character of our organization, please complete this form and return it to the program contact identified above. Your use of this form is voluntary.

If you object to the religious character of our organization, we must make reasonable efforts to identify and refer you to an alternate provider to which you have no objection. We cannot guarantee, however, that in every instance, an alternate provider will be available.

☐ Please check if you want to be referred to another service provider.

Please provide the following information:

Your Name: _____

Best way to reach you:

Phone Number: _____

Email Address: _____

FOR STAFF USE ONLY

1. Date of objection: ____/____/____

2. Referral (check one):

☐ Individual was referred to **Second Harvest Food Bank of North Central Ohio** to get a referral to another program in their service area. **(440) 960-2265**

Individual was referred to: _____

Name of alternate provider: _____

Contact Information: _____

☐ Individual was given State agency - provided referral information (i.e. a website, hotline, or list of other service providers funded by the State agency)

☐ Individual left without a referral

☐ No alternate service provider is available - summarize below what efforts you made to identify an alternate provider (including reaching out to State agency or local or eligible recipient agency):

_____

_____

_____

This Institution is an Equal Opportunity Provider

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