



Office of Community Services (OCS)
Department of Labor and Industrial Relations
State of Hawaii

Agency Name: _____

COMMODITY DISTRIBUTION

Agency #: _____ Date: _____

I certify that my yearly gross income is at or below that income listed on this form for households with the same number of people as my household, OR that my household participates in the program. I also certify that, as of today, my household lives in the County of Honolulu. This certification form is being completed in connection with the receipt of Federal assistance. Per State policy, program officials may verify what I have certified to be true. *I understand that making a false statement may result in having to pay the State for the value of the food improperly issued to me and may subject me to criminal prosecution under State and Federal law.*

2024 ANNUAL HOUSEHOLD INCOME GUIDELINES (300% of poverty) (more than 8 add \$18,570.00 for each additional person)

Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income
1	\$ 51,930.00	2	\$ 70,500.00	3	\$ 89,070.00	4	\$107,640.00	5	\$126,210.00	6	\$144,780.00	7	\$163,350.00	8	\$181,920.00

<u>Client's First and Last Name</u>	<u>Zip Code</u>	Household Information					<i>Agency Use Only</i>						
		<u># of Adult</u>	<u># of Children</u>	<u>Employed?</u> Yes or No	<u>Receives Gov't Asst?</u> Yes or No	<u>Armed Forces?</u> A = Active Duty V = Veteran N = No	<u>1st visit this month?</u> Yes or No	<u>REGULAR Food?</u> X = Yes	<u>SEFAP Food?</u> X = Yes	<u>TEFAP Food?</u> X = Yes	<u>Staff/Volunteer Initial</u>		
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