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.*

我證明我年總收入等於或低於下列表格上與我家庭人數相同者的收入,或是我家庭參加該計劃者. 我還證明,直到今天,我的家庭成員住在檀香山縣 (County of Honolulu) 此證明表格收據完成是跟據聯邦援助. 依照州政策,計劃官員可能驗證我的收據是否真實. 我明白假的陳述會引至要賠償卅不當發給我的食品,而且可能受州和聯邦 法律刑事起訴.

2026 ANNUAL HOUSEHOLD INCOME GUIDELINES (300% of poverty) (more than 8 add $19,590 for each additional person)

2026 年家庭總收入指導方針（貧窮綫300%）（超過8人，每一個人就增加$19,590）

Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income	Size	Income
1	$55,080	2	$74,670	3	$94,260	4	$113,850	5	$133,440	6	$153,030	7	$172,620	8	$192,210

Client's First and Last Name 客戶姓和名字	Zip Code 郵遞區號	Household Information 家庭資料					*Agency Use Only*			
		# of Adult #成人人數	# of Children 小孩人數	Employed 有職業? Yes or No 有 或 :無	Receives Gov't Asst 接受政府援助? Yes or No 有 或 無	Armed Forces 從軍? A = Active Duty 現役軍人 V = Veteran 退伍軍人 N = No 沒有	1st visit this month? Yes or No	REGULAR Food? X = Yes	TEFAP Food? X = Yes	Staff/ Volunteer Initial
	Page Totals									

OCS HFB DISTRIBUTION FORM
Revised 3/2026

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