



New York State Department of Health
Hunger Prevention and Nutrition Assistance Program

HPNAP FOOD LINE OF CREDIT APPLICATION: 2010 - 2011

(Please type or clearly print all responses)

Please return this original application to:

Foodlink
936 Exchange Street
Rochester, NY 14608
Attention: Line of Credit HPNAP 10-11

(we do not need extra copies)

Applications must be received by May 27th, 2010.

Name of Emergency Food Program: _____

Foodlink customer number: _____ Five-Digit HPNAP ID#: _____

County: _____

Physical Site Address: _____

_____ Zip Code: _____

Mailing Address: _____

_____ Zip Code: _____

Executive Director: _____

Telephone Number (weekdays 8a.m. – 5p.m.): _____

Email: _____

Person to be contacted regarding the administration of this grant:

Name: _____

Telephone Number (weekdays 8a.m. – 5p.m.): _____

Email: _____

Primary contact for shopping and Foodlink related questions:

Name: _____

Telephone Number (weekdays 8a.m. – 5p.m.): _____

Email: _____

1. Check the type of food program(s) for which you are applying:
(Use the same application for programs located at one address).

_____ Food Pantry or Food Cupboard	When did this program begin operating? Month _____ Year _____
_____ Hot Meals, Soup Kitchen	Month _____ Year _____
_____ Shelter (temporary shelter for homeless or victims of domestic violence)	Month _____ Year _____

2. How does your food program keep a record of the number of people you serve?

_____ Sign-in Sheet	_____ Assign numbers
_____ Checklist	_____ Seating Capacity
_____ Intake Records	_____ Other (specify) _____

3. Does your program have Internet access? If grant notices could be transmitted via e-mail, would you prefer this method? (If yes, please provide us with your e-mail address):

4. Over the past year, have you attended:

Foodlink's Annual Agency Conference and workshop day _____ Yes _____ No

If No, why not? _____

Any local or regional meetings on hunger issues _____ Yes _____ No

Please list name & location of meetings in your area: _____

5. What workshop topic(s) would be of interest to you on future meeting agendas:

6. Do you distribute fresh produce? _____ Yes _____ No

If "No" please explain: _____

7. What additional services / referrals does your program provide.

Child Health Plus/Family Health Plus

DSS/Medicaid

Food Stamps

Companionship/Emotional Support Other

WIC

Smoking Cessation

8. Please list three organizations that you frequently take referrals from:

(1) _____ (2) _____ (3) _____

9. Is your program currently listed with LIFELINE/ HELPLINE/211? ____ Yes ____ No
***If you operate in Monroe, Ontario, Livingston or Wayne county and are not currently listed,
please contact LIFELINE at (585) 275-5151***

10. Promoting Healthy Eating: *Obesity and heart related conditions have a significant impact on low-income populations. Adequate nutrient intake also influences energy level and work performance.* What does your program do to improve health through nutrition?

- Provide Meals or Food Packages with an Abundance of Fruits and Vegetables
- Provide/Promote Protein and Dairy Products which are Low in Saturated Fat
- Provide Recipes for Nutritious Foods
- Provide Handouts that Promote Healthy Eating Healthy Cooking Classes
- Host Demonstrations for Fruits and Vegetables Other

11. Providing Safe Food: *Due to the critical nature of food safety and high-risk populations, HPNAP encourages you to have as many of your workers participate in Food Safety Training as possible.*

- When was the last time staff attended food safety training with Foodlink? _____
- Monroe County Meal Programs: please list the names your L1 and L2 certified food handlers:
 Person with L1 Certification: _____ expiration date: _____
 Person with L2 Certification: _____ expiration date: _____

12. Training Opportunities

Please list the three workshop or training topics that would most benefit your program:

Please list the hours/days that are most convenient for your staff to attend trainings/workshops:

Would it be more convenient for your staff/volunteers if trainings were delivered at your site?

____ Yes ____ No

If so, could you assemble a group of ten or more people at a time? ____ Yes ____ No

Could your staff attend workshops at Foodlink ____ Yes ____ No

What topics would you like to see covered in an agency newsletter?

13. Please explain your service area – if serving specific zip codes please list them:

14. If in Monroe County list the sector that your program is in: _____

FOOD PANTRIES ONLY TO COMPLETE

(All other programs please skip this section)

Use numbers that were on your Local Agency Monthly Reports that were submitted to Foodlink during the last calendar year.

How many people did you serve from April 1, 2009 – March 31, 2010? _____

Please calculate the average number of persons served per month:

Total people served for the year _____ divided by 12 months = _____

Please calculate your “meal factor” using this formula: (Ex. 3 meals x 3 days= meal factor of 9)

Our “meal factor” is : _____

Please list the total number of meals served by multiplying total # of people by your meal factor.

Our meal total for 2009 is: _____

When answering the above question, follow these guidelines:

*Count each household member even if only one person picked up food at the pantry.

*Count every person each time they received food from your pantry.

***Please do not include numbers from mass distributions of food provided by Foodlink.**

What days and times is your pantry open for service?

If your pantry does not have the same schedule each week, describe the schedule below (for example, if it is open every other Tuesday or 1x each month).

Hours Open:

Monday _____ Friday _____

Tuesday _____ Saturday _____

Wednesday _____ Sunday _____

Thursday _____

If you have no “open hours” describe how your pantry service is made available to the public:

How many days of food for the household are provided in each package? _____

Please attach a list of the amount of food you provide per person or household.

How often will you provide food assistance to a household?

_____ No set limit (need is assessed each time)

_____ Once per month or once every 30 days

_____ Once every three months

_____ Other (describe): _____

Does your pantry require a referral before you will serve a client? ____ Yes ____ No
If yes, describe what type of referral (written or verbal? Who can refer?)

List all documentation required (if any) when a client comes to you for assistance:

What other Emergency Food Providers operate in your service area? (Please list name & type of program):

How do you coordinate with these providers in order to maximize your resources;

Please provide us with an overview of your program's staffing:

Number of paid staff _____ Number of hours per week _____

Number of volunteers _____ Number of hours per week _____

How do volunteers get connected with your program? _____

Do you offer volunteers compensation in the form of food/non-food gifts? ____ Yes ____ No

If "Yes," please explain: _____

Client Choice

Client choice is an approach used by pantries nationwide to allow clients input regarding the products that they are receiving when they visit an emergency food program such as yours. This can take a variety of forms:

- **Inventory list model** - A list of what the pantry has available that consumers can choose from and a volunteer packs the bag.
- **Walk-through or Retail model** - allows consumers to "shop" for what they need
- **Table model** – Food is set up on a table and clients get to choose and pack their food.
- **Window model** – client stand outside the pantry area but can see in the pantry and choose what they would like and a volunteer packs the bag.
- There can be other variations of client choice, you are not limited to these models.

Does your program currently engage in Client Choice? ____ Yes ____ No

If so, please describe:

If you answered no, please list some of the challenges that have prevented your program from offering Client Choice:

Would you be interested in on-site consultation and technical assistance to help your program develop a Client Choice model?

If so, please provide contact information:

Name: _____

Phone: _____ Email: _____

SOUP KITCHENS ONLY TO COMPLETE

(All other programs please skip this section)

***Please Note: As of July 1, 2005 Kids Cafes are no longer allowed to obtain HPNAP assistance if eligible to receive CACFP funding (Child & Adult Care Feeding Program)

Use numbers that were on your Local Agency Monthly Reports that were submitted to Foodlink during the last calendar year, or contact the Agency Services Department for assistance.

How many meals did you serve from April 1, 2009 – March 31, 2010? _____

To calculate the average number of meals served per month take the

Total meals served for the year _____ divided by 12 months = _____

Service Schedule: Which days of the week does your program serve? (please check):

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday

____ Saturday ____ Sunday

If your program does not have the same schedule each week (for example, if it is open one week per month), describe the schedule:

If your program is usually closed any months (e.g. during the summer), list what months it is closed:

Which meals does your program provide? Check the meals(s) provided and write the time served:

<u>MEAL</u>	<u>TIME SERVED</u>	<u># PERSONS SERVED PER MONTH</u>
____ Breakfast	_____	_____
____ Lunch	_____	_____
____ Dinner	_____	_____
____ Snack	_____	_____
____ Other (explain)	_____	_____

What is your maximum daily capacity: _____

Describe an average meal served at your program and attach a sample menu:

Describe any additional food-related services provided by your program:

Please provide us with an overview of your program’s staffing:

Number of paid staff _____ Number of hours per week _____

Number of volunteers _____ Number of hours per week _____

How do volunteers get connected with your program? _____

Do you offer volunteers compensation in the form of food/non-food gifts? ____ Yes ____ No

If “Yes,” please explain: _____

SHELTERS ONLY TO COMPLETE

(All other programs please skip this section)

Use numbers that were on your Local Agency Monthly Reports that were submitted to Foodlink during the calendar year, or contact Agency Services for assistance.

How many "person-days" of shelter did your program provide from April 1, 2009 – March 31, 2010?
(One person sheltered for one day = one "person-day").

To calculate the average number of person-days per month take:

_____ Person-days for the year divided by 12 months = _____

How many meals did your program provide to shelter guests last year? _____

Please count each guest served at each meal

If a guest received three meals per day, report all three meals.

To calculate the average number of meals per month take:

_____ meals for the year divided by 12 = _____

Does your shelter receive per diem payments from your county Department of Social Services or any other source for the persons sheltered? _____ Yes _____ No

If Yes, how much per person? _____ (Specify per day, week, month)

If your shelter is an enrolled program only, do you ever shelter persons "off the street"?

_____ Yes _____ No

Please check which type of shelter you are:

() Overnight only

() Women only

() Men only

() Rehabilitation shelter (must enroll in program to shelter)

() Other, explain _____

Describe an average meal served at your shelter. Attach a recent weekly or monthly menu.

What additional services does your shelter provide? _____

Is the shelter an emergency food service that is open to the general public? (if yes please explain)

_____ Yes _____ No

If yes, circle the meals served; Breakfast Lunch Dinner

Please provide us with an overview of your program's staffing:

Number of paid staff _____ Number of hours per week _____

Number of volunteers _____ Number of hours per week _____

How do volunteers get connected with your program? _____

Do you offer volunteers compensation in the form of food/non-food gifts? _____ Yes _____ No

If "Yes," please explain: _____