STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP) BENEFICIARY REFERRAL REQUEST

NAME OF ORGANIZATION

CONTACT INFORMATION FOR PROGRAM STAFF

NAME

TELEPHONE NUMBER	EMAIL ADDRESS (IF APPROPRIATE)

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 (TELEPHONE/ADDRESS/EMAIL)

FOR STAFF USE ONLY

1. DATE OF OBJECTION

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2. REFERRAL (CHECK ONE):

☐ Individual was referred to: _____
(NAME OF ALTERNATE PROVIDER AND 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 eligible recipient agency):

THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER