

# HIDDEN HARVEST



*Putting good food to good use*

Print and fill out this form to turn in to the Hidden Harvest office.

940 E Genesee Ave # 2, Saginaw, MI 48607

HIDDEN HARVEST  
RECIPIENT AGENCY APPLICATION

(Please type or print and answer all questions completely.)

Legal Name of Organization: \_\_\_\_\_

President/ Executive Director: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Other Approved Contact/Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Contact Person's Phone #: \_\_\_\_\_

Fax: \_\_\_\_\_ Email address: \_\_\_\_\_

Delivery Address (if different): \_\_\_\_\_ City/Zip: \_\_\_\_\_

Nearest Cross Streets: \_\_\_\_\_

Is your agency a non-profit organization? Yes \_\_\_\_\_ No \_\_\_\_\_

Non-Profit 501(c)(3): Yes \_\_\_\_\_ No \_\_\_\_\_; Church: Yes \_\_\_\_\_ No \_\_\_\_\_

(Your organization must have a 501(c)(3) tax exempt letter or qualify as a church per IRS standards)

Type of Agency / Program (please check all that apply):

\_\_\_\_\_ Food Pantry \_\_\_\_\_ Residential Facility / Program

\_\_\_\_\_ Shelter \_\_\_\_\_ Soup Kitchen

\_\_\_\_\_ Other (please describe) \_\_\_\_\_

Number of meals currently provided / served by your agency:

Daily: \_\_\_\_\_ Weekly: \_\_\_\_\_ Monthly: \_\_\_\_\_

Year Program Started: \_\_\_\_\_ Current Annual Operating Budget: \_\_\_\_\_

Does your agency have a refrigerator? Yes \_\_\_\_\_ No \_\_\_\_\_; Freezer? Yes \_\_\_\_\_ No \_\_\_\_\_

Specific geographic area to be served (include boundaries or cross streets): \_\_\_\_\_

How many people received food from your agency last year? \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

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Print Name and Title

Agency Name: \_\_\_\_\_ Date \_\_\_\_\_

1. What is your organization's mission?

2. Please provide a brief description of your agency's programs and activities.

3. How many people did you feed through your program(s) last year?

4. How much food (in pounds/meals) would you like to receive from HIDDEN HARVEST:  
(One pound of food = one meal.)

Weekly \_\_\_\_\_ Monthly: \_\_\_\_\_ Other: \_\_\_\_\_

5. Will you provide this food to families you are currently serving or will the additional food allow you to serve more families? If so, how many?

6. Please describe how you will distribute the perishable food you receive from HIDDEN HARVEST.

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Agency Name: \_\_\_\_\_ Date \_\_\_\_\_

7. What criteria do you use to determine client eligibility?

8. What kind of records (if any) do you keep regarding your clients?

9. Percentage of clientele served:

Preschool (0-5) _____ %	Male _____ %
Children (6-17) _____ %	Female _____ %
Adults (18-59) _____ %	
Seniors (60+) _____ %	

10. Special needs of participants *(please check all that apply)*:

- |  |   |
|--|---|
| <input type="checkbox"/> Low income<br><input type="checkbox"/> Unemployed<br><input type="checkbox"/> Single female heads of household<br><input type="checkbox"/> Grandparent heads of household<br><input type="checkbox"/> Recently laid off<br><input type="checkbox"/> Physical or mental disability | <input type="checkbox"/> Illiterate<br><input type="checkbox"/> Homeless<br><input type="checkbox"/> Domestic Abuse<br><input type="checkbox"/> None of these categories apply<br><input type="checkbox"/> Other: please explain _____<br>_____ |
|--|---|

11. What is the major "at-risk" factor among the clients your program serves?  
*(please check all that apply)*:

- |   |   |
|---|---|
| <input type="checkbox"/> Dropped out of school<br><input type="checkbox"/> Teen pregnancy<br><input type="checkbox"/> Juvenile delinquency<br><input type="checkbox"/> Substance abuser<br><input type="checkbox"/> Losing public benefits<br><input type="checkbox"/> Violent behavior | <input type="checkbox"/> HIV / AIDS/<br><input type="checkbox"/> Mental illness<br><input type="checkbox"/> Evicted<br><input type="checkbox"/> None of these categories apply<br><input type="checkbox"/> Other: please explain _____<br>_____ |
|---|---|

12. Please detail the days and hours of your program(s):

DAY	PROGRAM ACTIVITY (i.e.: pantry, shelter, soup kitchen)	HOURS OF PROGRAM
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

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SATURDAY		
SUNDAY		

Agency Name: \_\_\_\_\_ Date \_\_\_\_\_

13. Do you serve food? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many times per week do you serve:

Breakfast \_\_\_\_\_ Days \_\_\_\_\_ Number served \_\_\_\_\_

Lunch \_\_\_\_\_ Days \_\_\_\_\_ Number served \_\_\_\_\_

Dinner \_\_\_\_\_ Days \_\_\_\_\_ Number served \_\_\_\_\_

Snacks \_\_\_\_\_ Days \_\_\_\_\_ Number served \_\_\_\_\_

14. Do you deliver food outside your facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes please describe: \_\_\_\_\_

15. What types of foods best meet your needs? (*please check all that apply.*)

\_\_\_\_\_ Soups \_\_\_\_\_ Produce \_\_\_\_\_ Dairy

\_\_\_\_\_ Baked goods \_\_\_\_\_ Sandwiches \_\_\_\_\_ Breads

\_\_\_\_\_ Meats \_\_\_\_\_ Fish \_\_\_\_\_ Prepared Meals

\_\_\_\_\_ Other (*please list*) \_\_\_\_\_

16. Does someone on your staff who is handling food have a Safe Food Handling Certificate?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes please provide name(s): \_\_\_\_\_

17. Is your kitchen / storage area inspected by:

Department of Public Health Yes \_\_\_\_\_ No \_\_\_\_\_ County \_\_\_\_\_

Michigan Dept. of Agriculture Yes \_\_\_\_\_ No \_\_\_\_\_ County \_\_\_\_\_

18. On what days and during what hours would your agency be able to accept food deliveries?

19. Please tell us how this project will help your agency relieve hunger in the neighborhood(s) you serve.

Please include as attachments:

- 501(c)(3) tax exempt letter or Church Qualifier Form
- Copy of documentation verifying safe food handling training or ServSafe certification

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- Organizational brochure and / or most recent newsletter
- Current operating budget