State of Illinois -
Department of Human Services
**THE EMERGENCY FOOD ASSISTANCE PROGRAM -
MONTHLY SERVICE/DISTRIBUTION REPORT**

Date: _____

Agency: _____

Contact Person: _____ Phone: _____

Total Number of Times provided **SNAP Assistance (phone#, link, app)** this month: _____

Total Number of **Meals** Served: _____

Total Number of **Individuals** served this month: _____

Total Number of **Households** served this month: _____

Total Number of **SNAP Participants** this month: _____

Did this program distribute TANF products this month?   Yes ☐   No ☐

Total Number of **TANF Households** served this month: _____

Total Number of **TANF Children** served this month: _____

Was this program **closed** during any of its scheduled operating times this month?   Yes ☐   No ☐

If "Yes" please list dates and reasons: _____

Was this program **open any extra days or hours** during this month?   Yes ☐   No ☐

If "Yes" please list dates and reasons: _____

Did this program **run out of food** or **was anyone turned away**?   Yes ☐   No ☐

If "Yes" please list dates and why: _____

Please list this program's operational schedule:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
HOURS OF DISTRIBUTION							
EMERGENCY HOURS							

Completed this form no later than the _____ of the following month and submit to:

Foodbank: _____

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