

## Food Insecurity Screening in the Allergy/Immunology Clinic: A Work Group Report of the AAAAI Adverse Reactions to Foods Committee



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**What is already known about this topic?** Existing knowledge underscores food insecurity's (FI) adverse effects on health, particularly among children and low-income families. This is exacerbated by systemic racial disparities in food access and allergies.

**What does this article add to our knowledge?** Our project adds to the body of evidence illustrating the high prevalence of FI in the allergy/immunology population and the important role allergists can play in identifying patients affected by FI.

**How does this study impact current management guidelines?** The study underscores the need for routine FI screening in allergy clinics to tailor interventions, advocate for systemic change, and address racial and ethnic disparities in access to allergen-free foods.

Food insecurity (FI) is defined by the US Department of Agriculture as reduced quality, variety, or desirability of a diet or reduced or disrupted intake of food. There is concern that children with food allergy (FA) may be more likely to be food insecure. The purpose of this project was to investigate the prevalence of FI in the pediatric allergy/immunology population and determine the impact of FA status, race and ethnicity, and geographic food access. An additional goal was to develop a workflow for FI screening in the allergy/immunology clinic setting. Parents of patients were given the validated 2-question Hunger Vital Sign questionnaire in English or Spanish. Those with physician-diagnosed FA were asked a third question about access to allergen-free foods. Families who screened positive for FI received a list of local resources and access to social work assistance. The response rate was 89.1%, with 179 completed surveys. Twenty-three percent of patients screened positive for FI. There was a significant association between race and

ethnicity, age, and FI status. FA status and distance from the nearest grocery store were not significantly associated with FI. This study adds to the mounting evidence highlighting the burden of FI in the allergy/immunology population and serves as a call to action for practicing allergists. Efficient FI screening can be accomplished using widely available validated tools. Continued efforts will enable the development of targeted resources to meet this pressing need, with tailored solutions for those on specialized diets. © 2025 American Academy of Allergy, Asthma & Immunology (J Allergy Clin Immunol Pract 2025;13:1050-6)

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Food insecurity (FI) is increasingly recognized as an important social determinant of health, affecting millions of adults and

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received a speaker honorarium from Food Allergy Research & Education for her involvement in speakers bureaus, symposia, and as an expert witness. Lastly, she receives research support from Siolta, including participation in clinical trials, where she serves as a principal or named investigator. The rest of the authors declare that they have no relevant conflicts of interest.

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*Abbreviations used*

AAAAI- American Academy of Allergy, Asthma & Immunology

FA- Food allergy

FI- Food insecurity

HVS- Hunger Vital Sign

ICD-10- International Classification of Diseases, 10th Revision

USDA- US Department of Agriculture

children across the United States. FI is defined by the US Department of Agriculture (USDA) as reduced quality, variety, or desirability of a diet as well as disrupted or reduced food intake.<sup>1</sup> It is composed of 4 individual parts: availability, access, utilization, and long-term stability. Access includes geographical and economic access to safe foods, as well as access to culturally relevant foods. A 2021 USDA report found that 10.2% of households, approximately 38 million individuals, experience FI. Of households with children, 12.5% were found to be food insecure. Prevalence rates of FI varied across states, ranging from 5.4% in New Hampshire to 15.3% in Mississippi.<sup>2</sup> The prevalence of FI rose significantly by approximately one-third during the height of the COVID-19 pandemic, reaching 24.8% in March 2020, compared with 18.8% in the pre-COVID-19 period.<sup>3</sup> Notably, low-income families experienced a much higher surge in FI rates, with an 80% increase.<sup>4</sup> In addition, households with children were especially affected by FI, particularly when a nonworking member lived in the household.<sup>5</sup> Studies have highlighted an elevated risk of FI in people of color, even when controlling for confounding variables.<sup>6,7</sup> This suggests the potential impact of systemic racism in perpetuating unequal access to food across different racial and ethnic groups.

FI leads to many adverse outcomes for children, including negative physical and mental health outcomes, poor school performance, and problems with growth and development. It has been associated with negative developmental outcomes, including decreased reading and math scores in children.<sup>8,9</sup> In adults, FI has been linked to an increased risk of cardiovascular disease and diabetes, possibly due to the consumption of energy-dense but nutrient-poor foods.<sup>10,11</sup>

Geographic food access refers to an individual's ability to buy products within their community and has been identified as a critical concept when designing policies to minimize the level of FI within a community.<sup>12</sup> Racial and ethnic disparities have historically defined geographic food access, and studies continue to support this idea. A systematic review of studies from 1966 to 2007 found that areas with predominantly racial or ethnic minority populations were more likely to have restricted access to healthy foods than neighborhoods with predominantly non-Hispanic White populations.<sup>13</sup> Compared with predominantly White neighborhoods, minority communities are more likely to have restricted geographic access to grocery stores and less culturally appropriate healthy food options.<sup>14</sup>

Food allergy (FA) is a potentially life-threatening condition that affects approximately 32 million Americans, including 10.8% of adults and 7.6% of children in the United States.<sup>15</sup> In Texas, the rate of FI is 14%; the rate of FI in Austin/Travis County is similar, at 14.4%.<sup>16</sup> Food allergen avoidance is a central tenet of FA management. However, FA-related dietary restrictions can impose significant financial and health burdens on individuals as well as decreased quality of life, as specialized

diets are expensive and difficult to obtain, especially for low-income populations.<sup>17</sup> In a survey conducted to estimate the additional medical costs for families with children with food allergies, Gupta et al<sup>18</sup> found that families spent approximately 5 times more on medical care than children without food allergies.

Several studies have examined the association of FI with FA.<sup>19-21</sup> Coleman-Jensen et al<sup>22</sup> found that 39% of adults with food allergies experienced FI, and those with FI had significantly worse health-related quality of life, higher rates of anxiety and depression, and more severe allergic reactions. In pediatric populations, disparities were observed between White and Black caregivers regarding access to allergen-free foods, with White caregivers reporting improved access and higher likelihood of purchasing these foods online.<sup>23</sup> A study by Guillaume et al<sup>20</sup> found that households with dietary restrictions were more vulnerable to new or worsening FI, both before and during the COVID-19 pandemic. A similar study conducted by Golding et al<sup>24</sup> observed that households across varying income brackets facing FA incurred heightened direct and indirect expenditures related to food acquisition amid the COVID-19 pandemic. Moreover, a study by Tackett et al<sup>21</sup> found that caregivers of food-allergic children may perceive greater risk of allergen exposure at certain food purchase locations, which may exacerbate FI in these families. In addition, researchers discovered that over 20% of children with FA had low food security, and FI was most common among people with FA who come from low socioeconomic backgrounds.<sup>25</sup>

Although FI awareness is improving, a work group report by Shroba et al<sup>26</sup> found that the majority of the American Academy of Allergy, Asthma & Immunology (AAAAI) members did not routinely screen their patients for FI. Over 70% of respondents were unaware whether their patients faced FI in the past 6 months, and researchers found that the biggest barriers included a lack of knowledge regarding FI screening and difficulty identifying resources to support patients who screen positive. Screening can identify vulnerable populations and connect individuals and families with local resources and federal programs to reduce FI's prevalence and its effects on the community.<sup>27</sup> Universal assessment for FI helps reduce the stigma and allows the health care team to tailor interventions to meet the specific needs of patients and their families.<sup>28</sup> Implementing FI screening and providing appropriate resources to at-risk patients can potentially lead to reduced health care costs by ensuring improved access to safe, allergen-free foods and reducing emergency department and primary care visits.

The purpose of this project was to investigate the prevalence of FI in the pediatric allergy/immunology population and determine the impact of FA status, race and ethnicity, and geographic food access. An additional goal was to develop a workflow for FI screening in the allergy/immunology clinic setting.

## METHODS

The study protocol was approved by the University of Texas at Austin Institutional Review Board. Data collection took place from July 2022 to March 2023. The study was a cross-sectional single-center survey conducted in an urban, children's hospital-based specialty clinic affiliated with a medical school and serving a socioeconomically diverse population. Members of the research team attended randomly selected clinic sessions based on their availability, and team members approached all available patients during a given

clinic session. Informed consent was obtained from parents of pediatric patients, who were administered the validated Hunger Vital Sign (HVS) questionnaire, provided in English or Spanish. The HVS questionnaire consists of 2 questions designed to assess FI.<sup>26</sup> Children with physician-diagnosed FA were asked an additional question regarding access to allergen-free foods (Figure 1). Race and ethnicity data were extracted from the electronic medical record and were self-reported or entered by nonclinical staff. FI was defined as a positive response to one of the 2 HVS questions. Families that screened positive for FI were provided with a list of local resources compiled by registered dietitians and local food banks and were offered a meeting with the clinic social worker. The International Classification of Diseases, 10th Revision (ICD-10) code for FI, Z59.41, was added to the child's chart. An institutional grant was secured during the project that allowed for the provision of grocery cards to families who screened positive.

Sociodemographic analysis was performed using Stata statistical software (version 17.0; StataCorp, College Station, Texas). The City of Austin Food Environment Analysis was used along with updated grocery store addresses to calculate the distance from participants' residences to the nearest grocery store. This initiative mapped the food retail environment of Travis County, Texas. Using ArcGIS's Closest Facility Tool, the distance between each participant's zip code residence and the closest food retailer was calculated and recorded as a separate variable for analysis. Initial analysis involved measuring geographic food access in Travis County through the calculation of the distance from participants' residences to the nearest food retailer.

Descriptive statistics were used to determine the frequencies and percentages of categorical variables, whereas continuous variables were summarized using mean and standard deviation. The normality of continuous dependent variables was assessed using the Shapiro-Wilk test and visual inspection. Associations between FA status, race, and positive or negative screening were examined using  $\chi^2$  tests for categorical variables and *t* tests for continuous variables.

An additional exploratory analysis was completed to compare the distance from the nearest grocery store with race and ethnicity. An analysis of variance test was used to assess the relationship between the distance from the nearest grocery store and race and ethnicity, considering multiple dependent variables. Assumptions such as independence, normality, and equal variances were checked. *Post hoc* pairwise multiple comparisons were conducted to identify specific differences in distance from the nearest grocery store among different races and ethnicities.

## RESULTS

The study had a response rate of 89.1% of all patients who were approached (179 of 201 patient encounters). Notably, all participants with a documented FA responded to the additional question addressing the impact of FA. Over 23% (*n* = 42) of participants screened positive for FI (Table I). Patient age ranged from 9 months to 20 years. Age was found to be significantly associated with FI status (*P* < .052). Patients screening positive for FI had an average age of 8 years, whereas those screening negative for FI had an average age of 6.4 years. The study revealed significant association between FI and race and ethnic backgrounds (*P* < .00001). Asian patients had the lowest prevalence of FI, with only 9.1% experiencing FI. Over 38% of Black patients screened positive for FI. White Hispanic patients demonstrated the highest prevalence of FI within the study

For each of the following statements, please tell me which one is "often true," "sometimes true" or "never true" for the past 12 months, that is since last [name of current month].		
1. We (I) worried whether our food would run out before we (I) got money to buy more		
Often true	Sometimes true	Never true
2. The food that we (I) bought just didn't last and we (I) didn't have money to get more		
Often true	Sometimes true	Never true
Please answer question 3 only if you have a child with a documented food allergy.		
3) We (I) worried that my child's allergen-free food(s) would run out before we (I) had money to buy more.		
Often true	Sometimes true	Never true

FIGURE 1. Hunger Vital Sign Questionnaire.

population, with 46.9% screening positive; only 12.7% of White non-Hispanic children screened positive. There were no participants who identified with more than one race and ethnicity category. Insurance status was significantly associated with the FI; patients with Medicaid had a higher rate of FI (59.6%) than those with private insurance (6.6%) (*P* < .00001).

Of the families who were surveyed, 93 of 179 (52%) families reported FA. The rate of FI in patients with FA was found to be 20.4%. There was no statistically significant association between FI status and the presence of FA (*P* = .30). Of those with FA, 80% (52 of 65) had more than 1 FA. All respondents had a primary FA to one of the top 9 food allergens. Eighty-five percent of individuals had IgE-mediated FA; the remainder had non-IgE-mediated reactions, such as food protein-induced enterocolitis syndrome. Geospatial analysis was performed to assess the potential impact of proximity to grocery stores on food security (Figure 2). Notably, no statistically significant mean differences in distance were found when analyzing by FI, race and ethnicity, FA diagnosis, and health insurance, indicating that geographic proximity to grocery stores was not associated with FI in the study population (Table II).

## DISCUSSION

FI is a multifaceted social determinant of health that affects millions of adults and children across the United States and poses significant challenges to the well-being of individuals and families.<sup>1</sup> Childhood FI adversely affects well-being, growth, development, and education<sup>29</sup> and has been linked to compromised immunity, mental health concerns,<sup>30</sup> poor school performance, and cognitive challenges.<sup>31</sup> FA, like other conditions with medically necessary specialized diets, can increase vulnerability to FI, as affected children already face nutritional and growth challenges. Accumulating evidence demonstrates the high burden of FI in FA populations.<sup>20,32-34</sup> Allergen-free foods are often more expensive and can be difficult to procure. Recent shortages due to disruptions in the food supply chain and formula recalls have compounded the challenges faced by those on specialized diets.

An AAAAI Work Group Report highlighted that most allergists do not screen for FI due to barriers such as lack of knowledge regarding screening methods and difficulty identifying or accessing resources to support those who screen positive.<sup>26</sup> The HVS is a short questionnaire that has been validated in many patient populations. Administering the HVS was an

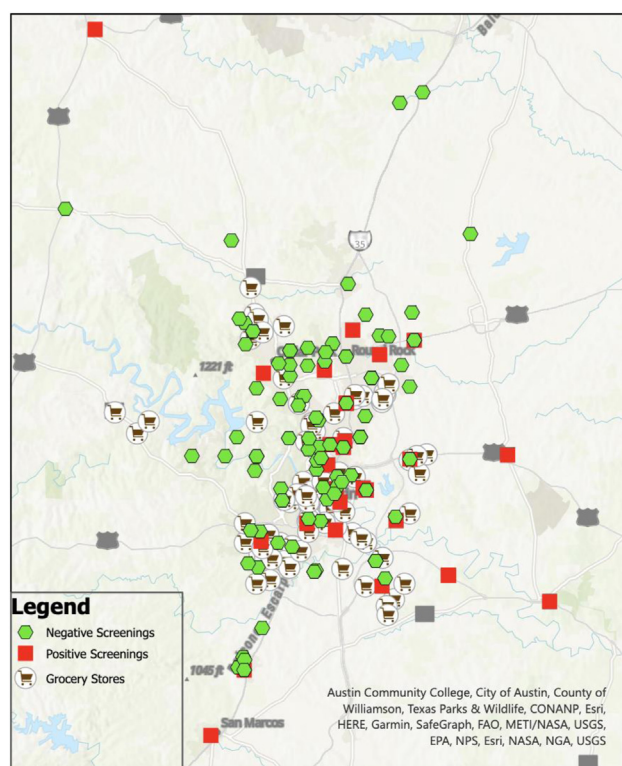
**TABLE I.** Descriptive statistics of variables by food insecurity status

Variable	Negative food insecurity screen, n (N = 137)	Positive food insecurity screen, n (N = 42)	Test statistic	P value	All participants, mean $\pm$ SD or n (%)
Age (y)	6.4	8.0	-1.96	<.052*	6.7 $\pm$ 4.88
Race and ethnicity			25.67	<.00001†	
Asian	10	1			11 (6.11)
Black	8	5			13 (7.22)
White, non-Hispanic	55	8			64 (35.56)
White, Hispanic	26	23			49 (27.22)
Other/not identified	38	5			43 (23.89)
Food allergy			1.07	.30†	
Yes	74	19			94 (52.22)
No	63	23			86 (47.78)
Health insurance			60.6	<.00001†	
Private	114	8			122 (68.16)
Medicaid	23	34			57 (31.84)

SD, Standard deviation.

\*The *t* test was used for the *P* value.

†The  $\chi^2$  test was used for the *P* value.



**FIGURE 2.** Geospatial model of Travis County.

efficient method of screening for FI in a pediatric allergy/immunology clinic. We added an additional question for pediatric patients with a diagnosed FA. Using the Z59.41 ICD-10 diagnosis code for FI enhanced tracking of patients and intervention. On a larger scale, consistent use of this diagnosis code can provide data on population trends and inform health policy.

The prevalence of FI in the sampled population (23.5%) was higher than the prevalence of FI for Austin/Travis County in

2022 (14.4%), underscoring the pressing nature of the problem in this population.<sup>35</sup> This finding highlights the need for targeted interventions to address FI in this specific group. Age was significantly associated with FI, with older children potentially at higher risk of FI; this finding warrants investigation into age-related dynamics. There was a strong association between race and ethnicity and FI status, with LatinX and Black children experiencing a disproportionate impact. Insurance status was also strongly associated with FI, with almost 60% of children on Medicaid screening positive for FI. This highlights an especially at-risk population whose basic needs are not being met. The prevalence of FI among patients with FA was 20.4%, a figure that aligns with other studies.<sup>19,25</sup> Children with and without FA were equally as likely to be food insecure. It was found that most food-allergic subjects reported multiple food triggers (80%). This was an important finding as each additional FA adds additional restrictions to diets and food items available to families. All individuals with reported FA reported allergy to one of the top 9 most common food allergens.

Addressing the complex landscape of FI extends beyond its direct impacts. Burke et al<sup>36</sup> conducted a study investigating the association between long-term racial discrimination and FI among Black households with children and revealed a significant connection between racial discrimination and the incidence of FI. Household characteristics such as single caregiver households, income levels below 185% of the federal poverty line (equivalent to a household income of less than \$27,750 for a family of four as of 2022), and children in immigrant, Native American, and Alaska Native households are correlated with FI.<sup>37,38</sup> The impact of FI may be amplified in families facing other poverty-related challenges, such as housing insecurity, lack of affordable child care, unreliable transportation, and low wages.<sup>38</sup>

The issue of equitable food access has historically extended to children of color with food allergies. In a recent study, researchers explored access to allergen-free foods among Black and White children with food allergies in urban US centers and found pronounced racial disparities in access to allergen-free foods.<sup>34</sup> Notably, White caregivers (88.1%) were more likely to report

**TABLE II.** Descriptive statistics of variables by distance from nearest grocery store in miles

Variable	Distance from nearest grocery store in miles (mean $\pm$ SD)	P value
Food insecurity screen		.4140
Negative*	7.85 $\pm$ 1.16	
Positive	9.93 $\pm$ 2.52	
Race and ethnicity		.6467
Asian	3.64 $\pm$ 7.07	
Black	7.98 $\pm$ 9.59	
White, non-Hispanic*	8.91 $\pm$ 15.90	
White, Hispanic	7.20 $\pm$ 13.10	
Other/not identified	10.31 $\pm$ 14.12	
Food allergy		.461
Yes	8.28 $\pm$ 1.31	
No*	8.47 $\pm$ 1.66	
Health insurance		.5391
Private	8.21 $\pm$ 1.81	
Medicaid	8.47 $\pm$ 1.32	

SD, Standard deviation.

\*Indicates the reference group.

access than Black caregivers (59%), with White caregivers also exhibiting a higher propensity for purchasing allergen-free foods online (35.2%) than Black caregivers (12%). The unadjusted analysis indicated that White children were 5.2 times more likely to possess access to allergen-free foods than Black children ( $P < .001$ ). However, after accounting for demographic factors, the racial disparity in access became statistically nonsignificant. Factors such as online food purchasing, annual household income, respondent education level, milk allergy, and child age over 5 years were also predictive of access to allergen-free foods. This study underscores that while racial disparities exist in access to allergen-free foods among Black and White children, socioeconomic status and various participant attributes substantially contribute to mediating these differences.

Other studies found that people of color are more susceptible to FI, even after accounting for other socioeconomic factors.<sup>23,36</sup> The roots of these disparities are deeply entwined with historical and systemic issues, such as racial discrimination, unequal access to resources, and residential segregation.<sup>39</sup> As a result, families from minority communities may face limited geographic access to grocery stores and culturally appropriate healthy food options, perpetuating the cycle of FI.<sup>40</sup> Moreover, heightened concerns about allergen exposure at specific food purchase locations among caregivers of food-allergic children, as observed in the study by Tackett et al,<sup>21</sup> could further exacerbate FI in these vulnerable households.

Geospatial analysis examined regional disparities and trends associated with FI, allowing analysis of the distribution of FI and its correlation with factors such as proximity to grocery stores and access to culturally appropriate and affordable food options. However, no significant differences in FI status were observed when assessing distance from the nearest grocery store by race and ethnicity, different from previous findings.<sup>13</sup> This may be due to the small sample size or the use of zip codes rather than individual addresses, as access to grocery stores can vary even within zip codes. Further study is needed to better understand geographic patterns of FI and design targeted interventions and

health policy to address the underlying causes to improve food access and reduce disparities.

A strength of our study was the high response rate of 89.1%, which may be attributed to several strategically implemented elements designed to enhance participant involvement. The short survey format facilitated subject participation and survey completion. The utilization of in-person survey administration by a designated FI team at the end of the visit and separate from intake forms was another unique feature that may have contributed to the high response rate. This approach facilitated an atmosphere of trust and privacy that promoted participation. Given the sensitive nature of the subject matter, an emphasis on maintaining participant confidentiality was crucial in ensuring that respondents felt safe sharing their experiences. Although broad application of this screening approach may be limited by available staff resources and time, several lessons learned can be applied in a practice setting without a dedicated team. These include the use of a short survey format and fostering an environment of trust and privacy within an established physician-patient relationship.

Limitations of the study include the small sample size, as survey administration was constrained by the availability of the research team due to schedules. Team members were available to approach patients only during certain clinic sessions, affecting the generalizability of results. We acknowledge the need to contextualize the response rate accordingly, as the rate reported reflects only the patients who were approached to participate. A goal of this pilot project is to assess how to optimally integrate FI screening into clinic workflow for broader implementation and to capture a more representative patient sample. In addition, this study was performed in a dedicated pediatric allergy practice and therefore did not assess the impact of FI in adults and limits generalizability of our results. This is an important area of future study.

Another potential source of selection bias is the voluntary nature of participation. It is possible that families experiencing more severe FI or other barriers to participation may have been less likely to participate in the study, thereby affecting the representativeness of our sample. Consequently, the prevalence of FI in our sample may not fully reflect the true prevalence in the pediatric allergy/immunology population. Moreover, the use of a convenience sample from a single clinic may limit the generalizability of our findings to other regions or health care settings. Future research should aim to include larger and more diverse samples from multiple clinics and geographic locations to enhance the external validity and generalizability of the results.

In addition, this study relied on self-reported data, which may introduce recall bias or social desirability bias. Participants may have under-reported their FI status due to stigma or discomfort, leading to potential inaccuracies in the data. To address these limitations, future studies could use more comprehensive and objective measures of FI, such as examining food purchasing behaviors, neighborhood characteristics, and access to food retail environments. This approach would provide a more nuanced understanding of the relationship between FI status, race and ethnicity, geographic food access, and FI. Furthermore, race and ethnicity data extracted from the electronic medical records were primarily self-reported or entered by nonclinical staff, which could introduce variability or inaccuracies in the data collection process. A future direction for improving the reliability of this data could involve confirming race and ethnicity information at

the time of survey administration. The literacy level of participants may have influenced study participation, as data collection was conducted through a written survey. This could potentially introduce bias, as individuals with lower literacy levels may have faced challenges in accurately completing the survey or declined altogether.

Although our study found a similar rate of FI in children with and without FA, it is crucial to acknowledge that other research has highlighted a potential connection between these 2 factors. Research has demonstrated that limited availability of allergy-friendly food, medication, and health care may result in increased morbidity, especially among minority children, due to potential issues related to compromised nutrition and delayed treatment of allergic reactions.<sup>25</sup> There is evidence supporting an association between residing in a food desert and the presence of an FA diagnosis in children.<sup>41</sup> This underscores the importance of screening for FI, especially in clinical settings, as individuals with food allergies may face unique challenges in accessing safe and nutritious food. Future studies may investigate the role of other factors that can modify the presentation and impact of FA, such as the presence of comorbid conditions like asthma and atopic dermatitis.

Screening for FI and better understanding its prevalence in a population are the first steps in designing interventions to address the problem. Handouts were developed with input from local dietitians, social workers, and food banks and provided practical local resources for families, including food pantries and assistance programs (Figures E1 and E2). Pilot data were submitted to apply for an institutional grant, which has allowed for the provision of grocery cards to all families who screen positive. Investigating local philanthropic foundations, institutional/hospital-based funding, and antihunger organizations can reveal sources of funding for such efforts. Next steps include examining the feasibility of an on-site food pantry with allergen-free foods, which can help address FI at the point of care.

Understanding the role of race and ethnicity in FI is instrumental in fostering a more inclusive and equitable approach to addressing this issue. In this study, Black and LatinX children were found to be disproportionately affected by FI. Identifying these disparities allows for advocacy and development of targeted interventions and policies that address the systemic issues underlying these patterns.<sup>42</sup> Promoting equitable access to nutritious and affordable food for all children can address gaps and improve health outcomes for all patients.

Identifying patients affected by FI is an important part of caring for the whole patient and family. This analysis carried out in a children's hospital-based allergy/immunology clinic revealed that almost 1 in 4 children were food insecure, with older children, Black and LatinX children, and those on Medicaid insurance disproportionately affected. Understanding the scope of the problem and its impact on a child's basic needs fundamentally influences the treatment plan. The influence of FI on various health disparities makes it a prime target for comprehensive interventions aimed at improving overall health. Investigating how race-related experiences within specific communities are linked to FI can inform the development of tailored food security interventions targeted at minority populations. These efforts can play a vital role in enhancing food access and health outcomes for all children. Allergists are uniquely positioned to identify patients and families affected by FI by virtue of long-term physician-patient relationships and as the primary specialty managing FA, a

diet-managed condition. By implementing routine screening, the practicing allergist can take a first and important step in addressing this vital social determinant of health.

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ONLINE REPOSITORY

## EMERGENCY FOOD ASSISTANCE REFERRAL LIST

**FIRST CHECK** [centraltexasfoodbank.org/find-food](https://centraltexasfoodbank.org/find-food)  
**OR CALL FOR HELP** **877.541.7905**

Information is subject to change, so confirm ahead with the pantry or the Food Bank.  
For additional resources (i.e. housing, clothing, healthcare) call 2-1-1 or visit [www.211texas.org](https://www.211texas.org).

What is the Central Texas Food Bank? Nearly one in six people and one in four children in Central Texas are food insecure. The Central Texas Food Bank, opened in 1981, is a 501(c) 3 non-profit organization that receives, stores and distributes food and grocery items through our programs and network of Agencies in 21 Central Texas counties. The Food Bank service area covers 19,064 square miles in Central Texas.



### USDA Nondiscrimination Statement

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: <https://www.usda.gov/casct/how-to-file-a-program-discrimination-complaint> and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

## State Benefits Application Assistance and Renewals

SNAP (Food Stamps), Medicaid, CHP Perinatal, Temporary Assistance for Needy Families (TANF), Healthy Texas Women (HTW)

**Benefits assistance hours by appointment: Monday – Friday 8:00 A.M. – 5:00 P.M.**

**Call 1.855.366.3401**

**[centraltexasfoodbank.org/SNAP](https://centraltexasfoodbank.org/SNAP)**

Scan this QR code for more information



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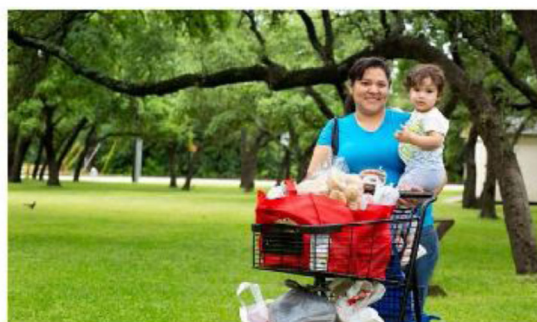
FIGURE E1. Resource Handout (English).

## LISTA DE REFERENCIA DE ASISTENCIA ALIMENTARIA DE EMERGENCIA

**PRIMERO VISITE [centraltexasfoodbank.org/find-food](https://centraltexasfoodbank.org/find-food)  
O LLAME POR AYUDA 877.541.7905**

La información puede cambiar. Si tiene preguntas favor de llamar al número asignado para cada centro de distribución, o contacte al Central Texas Food Bank. Para conseguir recursos adicionales, llame al 2-1-1 o visite [www.211texas.org](http://www.211texas.org).

¿Qué es el Central Texas Food Bank? Casi una de cada seis personas y uno de cada cuatro niños, en el centro de Texas, padecen inseguridad alimentaria. El Central Texas Food Bank, inaugurado en 1981, es una organización sin fines de lucro 501 (c) 3 que recibe, almacena y distribuye alimentos y artículos de comestibles a través de nuestros programas y redes de agencias en 21 condados en el centro Texas. El área de servicio del Banco de Alimentos cubre 19.064 millas cuadradas en el centro de Texas.



### Declaración de no discriminación del USDA

De acuerdo con las leyes federales de derechos civiles y las regulaciones y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), el USDA, sus agencias, oficinas y empleados y las instituciones que participan o administran programas del USDA están prohibidos de discriminar por raza, Nacionalidad, sexo, discapacidad, edad o represalias por actividades anteriores de derechos civiles en cualquier programa o actividad realizada o financiada por USDA.

Las personas con discapacidades que requieran medios alternativos de comunicación para información del programa (por ejemplo, Braille, letra giga, cinta de audio, lenguaje de señas americano, etc.) deben comunicarse con la Agencia (estatal o local) donde solicitaron beneficios. Las personas sordas, con problemas de audición o con discapacidades del habla pueden comunicarse con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339. Además, la información del programa puede estar disponible en otros idiomas que no sean el inglés.

Para presentar una queja de discriminación en el programa, complete el Formulario de Queja de Discriminación del Programa del USDA (AD-3027) que se encuentra en línea en: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> y en cualquier oficina del USDA, o escriba un Carta dirigida al USDA y proporcione en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de queja, llame al (866) 632-9992. Envíe su formulario o carta al USDA por: (1) correo: Departamento de Agricultura de los Estados Unidos Oficina del Subsecretario de Derechos Civiles 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; O (3) correo electrónico: [program.intake@usda.gov](mailto:program.intake@usda.gov).

### ASISTENCIA Y RENOVACIONES DE SOLICITUDES DE BENEFICIOS ESTATALES

(SNAP (cupones de alimentos), Medicaid, CHIP Perinatal, Asistencia Temporal para Familias Necesitadas (TANF), Healthy Texas Women (HTW))

#### Horas de asistencia beneficios con cita previa:

lunes a viernes de 8:00 a.m. a 5:00 p.m.

Llame al 1.855.366.3401 o visite [centraltexasfoodbank.org/SNAP](https://centraltexasfoodbank.org/SNAP)



Escanea este código QR para más información

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FIGURE E2. Resource Handout (Spanish).