###### **Commodity Supplemental Food Program Application**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Application type: (Select by placing an x in appropriate box)** CERTIFICATIONRECERTIFICATION Is the applicant or any qualifying household member participating in WIC or CSFP at another site?  YES  NO | | | | | | | | | | | | | | | | | | | | | | |
| NAME OF APPLICANT | | | | | | | | NAME OF GUARDIAN (if applicable) | | | | | | | | | | | | | | |
| PHYSICAL ADDRESS | | | | | **CITY/ZIP CODE** | | | | | | | | | | **COUNTY** | | | | | | | |
| MAILING ADDRESS (if different) | | | | | CITY/ZIPCODE | | | | | | | | | | **TELEPHONE NUMBER** | | | | | | | |
| CLIENT CASE NUMBER | | | | APPLICANT’S DATE OF BIRTH | | | | | | | | | | | TOTAL NO. LIVING IN HOUSEHOLD | | | | | | | |
| NAMES OF QUALIFYING HOUSEHOLD MEMBERS (attach separate) | | | | | | | | | | AGE | | | DATE OF BIRTH | | | | CASE NUMBER | | | | CATEGORY | |
|  | | | | | | | | | |  | | |  | | | |  | | | |  | |
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| **\*Women, infants and children – enter applicant information above and view proof of:**  **SNAP participation**  **TANF participation**  **Medical Assistance OR complete income section below.** | | | | | | | | | | | | | | | | | | | | | | |
| CHANGES MUST BE REPORTED: Participants must report changes in household income or composition within 10 days after the change becomes known to the household. | Indicate the source and amount of current (last month’s) income before any deductions, such as taxes and social security. This amount must include income of all household members. “Other” income would include commissions; strike benefits, income from trusts, contributions from relatives, etc. If last month’s income is not representative of usual household income, also indicate household’s average income during the previous 12 months. | | | | | | | | | | | | | | | | | | | | | |
| HOUSEHOLD INCOME | | | | | | | | **AMOUNT** | | | | | | | | | | **HOW OFTEN RECEIVED** | | | |
| GROSS SALARY, WAGES | | | | | | | |  | | | | |  | | | | |  | | | |
| SOCIAL SECURITY | | | | | | | |  | | | | |  | | | | |  | | | |
| PUBLIC ASSISTANCE (WELFARE) | | | | | | | |  | | | | |  | | | | |  | | | |
| CHILD SUPPORT (ALIMONY) | | | | | | | |  | | | | |  | | | | |  | | | |
| PENSIONS/RETIREMENT | | | | | | | |  | | | | |  | | | | |  | | | |
| SELF-EMPLOYMENT | | | | | | | |  | | | | |  | | | | |  | | | |
| UNEMPLOYMENT | | | | | | | |  | | | | |  | | | | |  | | | |
| OTHER INCOME | | | | | | | |  | | | | |  | | | | |  | | | |
| TOTAL HOUSEHOLD INCOME | | | | | | | |  | | | | |  | | | | |  | | | |
| RACIAL ETHNIC DATA (OPTIONAL) | | | | | | | | | | | | | | | | | | | | | | |
| Are you of Hispanic or Latino origin? (For statistical purposes only)  **YES  NO**  YES  NO | | | | | | | | | | | | | | | | | | | | | | |
| What is your race? (Select one or more) | | | AMERICAN INDIAN OR ALASKA NATIVE | | | | ASIAN | | | | | BLACK OR  AFRICAN AMERICAN | | | | NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER | | | | | | WHITE |
|  | | |  | | | |  | | | | |  | | | |  | | | | | |  |
| **Before signing, be aware of your rights AND WHAT YOUR SIGNATURE MEANS:**   * Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability. * You may appeal any decision made by the local agency regarding your denial or termination from the Program. * You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance. * If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate. | | | | | | | | | | | | | | | | | | | | | | |
| This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I am also aware that I may not receive both CSFP and WIC benefits simultaneously; I may not receive CSFP benefits at more than one CSFP site at the same time; and improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me to recover the value of the benefits and may lead to disqualification from CSFP. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.  I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.)  YES  NO | | | | | | | | | | | | | | | | | | | | | | |
| SIGNATURE OF APPLICANT OR GUARDIAN | | | | | | | | | | | | | | | | | DATE | | | | | |
| UPDATE INFORMATION, SIGN AND DATE FOR CERTIFICATION AFTER WAITING ON LIST | | | | | | | | | | | | | | | | | DATE | | | | | |
| \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* FOR CERTIFYING AGENCY USE ONLY \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* | | | | | | | | | | | | | | | | | | | | | | |
| IDENTITY/ELIGIBILITY/AGE  Describe proof: | | RESIDENCY VERIFIED  HANDOUT GIVEN  WIC HANDOUT GIVEN | | | | APPLICANT  ELIGIBLE?  Y  N | | | | | CATEGORY:  CH ELD | | | | CASELOAD AVAILABLE?  Y  N | | | | | DATE WRITTEN NOTICE GIVEN: | | |
| CERTIFYING OFFICIAL SIGNATURE | | | | | | | | | | | DATE CERTIFIED | | | | | | | PERIOD OF CERTIFICATION  1st Mo: Last Mo: | | | | |

**2019 Income Eligibility Guidelines**

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| --- | --- | --- | --- | --- |
| Household Size | Senior (Maximum Monthly Household Income) | Senior(Maximum Annual Household Income) | WIC (Maximum Monthly Household Income) | WIC (Maximum Annual Household Income) |
| 1 | $1,354 | $16,237 | $1,872 | $22,459 |
| 2 | $1,832 | $21,983 | $2,538 | $30,451 |
| 3 | $2,311 | $27,729 | $3,204 | $38,443 |
| 4 | $2,790 | $33,475 | $3,870 | $46,435 |
| 5 | $3,269 | $39,221 | $4,536 | $54,427 |
| 6 | $3,748 | $44,967 | $5,202 | $62,419 |
| 7 | $4,227 | $50,713 | $5,868 | $70,411 |
| 8 | $4,705 | $56,459 | $6,534 | $78,403 |
| For each additional family member, add | $479 | $5,746 | $ 666 | $ 7,992 |

# ELDERLY PARTICIPANT EXTENSION OF CERTIFICATION PERIOD

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME OF PARTICIPANT | | | QUALIFYING HOUSEHOLD MEMBERS | | | | |
| ADDRESS | | CITY/ZIP CODE | | COUNTY | | TELEPHONE NUMBER | |
| \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* FOR ELDERLY RECERTIFICATION USE ONLY \* \* \* \* \* \* \* \* \* \* \* \* \* \* | | | | | | | |
| * Participants address and continued interest in receiving CSFP benefits has been verified. * Local agency has sufficient reason to believe participant (s) still meets the income eligibility standards (e.g. the elderly person has a fixed income) * Local agency has notified participant verbally or in writing of the period of the extension. | | | | | | | |
| CERTIFYING OFFICIAL SIGNATURE | APPLICANT SIGNATURE | | | | DATE CERTIFIED | | PERIOD OF CERTIFICATION  1st Month: Last Month: |
| CERTIFYING OFFICIAL SIGNATURE | APPLICANT SIGNATURE | | | | DATE CERTIFIED | | PERIOD OF CERTIFICATION  1st Month: Last Month: |
| CERTIFYING OFFICIAL SIGNATURE | APPLICANT SIGNATURE | | | | DATE CERTIFIED | | PERIOD OF CERTIFICATION  1st Month: Last Month: |
| CERTIFYING OFFICIAL SIGNATURE | APPLICANT SIGNATURE | | | | DATE CERTIFIED | | PERIOD OF CERTIFICATION  1st Month: Last Month: |
| CERTIFYING OFFICIAL SIGNATURE | APPLICANT SIGNATURE | | | | DATE CERTIFIED | | PERIOD OF CERTIFICATION  1st Month: Last Month: |

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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.ascr.usda.gov/filing-discrimination-complaint-usda-customer>, 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;

1. fax: (202) 690-7442; or
2. email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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