Commodity Supplemental Food Program (CSFP) Participant Application
CSFP-1

Name of Applicant: _____

Address: _____
(Number/Street) (City) (Zip) (County)

Phone_____ Household Size____

Household Members:	**Age:**	**Date of Birth:**	**Category: 100% Elderly**	**What is your ethnic category:** (select only one)		**What is your race?** (select one or more)	
					Hispanic or Latino		American Indian or Alaska Native
							Asian
					Not Hispanic or Latino		Black or African American
							Native Hawaiian or Other Pacific Islander
							White

RACIAL/ETHNIC HERITAGE: This information is for reporting purposes only. You do not have to give us this information. However, providing this information will help us to follow the Federal Civil Rights Law. If you do not provide this information, it will not affect your case.

HOUSEHOLD INCOME	Gross Amount	How often received	Extension (Amount x Freq)
- Social Security			
- Pension, Retirement			
- Wages, Salary			
-TANF, General Assistance			
- SSI			
- Unemployment, Worker's Comp.			
- Other (Specify):_____			

TOTAL HOUSEHOLD GROSS MONTHLY INCOME: $_____

APPLICANT'S RIGHTS: 1) Standards for participation in the Program are the same for everyone regardless of race, color, sex, national origin, age or disability. **2)** You may appeal any decision made by the local agency regarding your denial or termination from the Program. You have a right to a fair hearing. **3)** If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate. **4)** The local agency will also provide information on nutrition, health or assistance programs and make referrals as appropriate.

APPLICANT'S RESPONSIBILITIES: Failure to comply with the rules below may result in disqualification from participation in the Commodity Supplemental Food Program. **1)** Do not make false statements orally or in writing in order to obtain benefits to which you or your household would not otherwise be eligible. **2)** Do not conceal information in order to obtain benefits for which you are not eligible. **3)** Do not alter Program documents for the purpose of receiving increased benefits for which you are not eligible or for the purpose of transferring benefits to an unauthorized individual. **4)** Do not use supplemental foods in an unauthorized manner, such as trading or selling the foods. **5)** Do not commit dual participation.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

COMPLAINT PROCESS: To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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 **complaint form or letter** to USDA by:

(1) Mail: U.S. Department of Agriculture
Director, Center for Civil Rights Enforcement
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CERTIFICATION STATEMENT: 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, and I may not receive CSFP benefits at more than one CSFP site at the same time. 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.

The participant further understands that changes in household income or composition must be reported within 10 days after the change becomes known to the household

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 _____ **Date**_____

Name/Signature of Proxy (optional) _____ **Date**_____

For Office Use Only **Applicant Name:**

Date of initial visit household applied for participation: _____ Identification Verified: _____
Form of Identification Verified: _____

Criteria used to determine the person's eligibility or ineligibility: _____

Categorically eligible: [ ] Yes [ ] No

REFERRAL: Income eligible under existing Federal, State, or local food, health, or welfare programs
[ ] Yes [ ] No [ ] NA List Program _____

Resides in local agency service area [ ] Yes [ ] No [ ] NA

ELIGIBILITY DETERMINATION

[ ] Approved: Certification Period: _____ to _____

Signature of Certifier_____ Date_____

[ ] Denied due to: _____

Signature of Certifier_____ **Date**_____

Written Information Provided (circle): Nutrition, Medicaid, TANF, other health insurance programs for low-income households, Food Stamp Program, SSI, Medicare, Child Support, WIC.

Referrals made, if applicable: _____