

# COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) PARTICIPANT APPLICATION

Enrollment Date:		Date of Verbal Recertification:	<input type="checkbox"/> 12 Months:
Site:			<input type="checkbox"/> 24 Months:

\_\_\_\_\_ Total In Household      \_\_\_\_\_ Total Qualifying Members

## COMMODITY SUPPLEMENTAL FOOD PROGRAM QUALIFYING MEMBERS

<b>1. Applicant</b> (Last Name, First Name):			
Address:		City, State, Zip Code:	
		<input type="checkbox"/> Verified Proof of Residency	
Date of Birth:	ID Number:	Phone Number:	
Hispanic / Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (choose one or more): <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Native Alaskan		
<b>2. Applicant</b> (Last Name, First Name):			
Date of Birth:	ID Number:	Phone Number:	
Hispanic / Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (choose one or more): <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Native Alaskan		

I certify under penalty of perjury that my household income for the past 30 days does not exceed the Commodity Supplemental Food Program posted monthly guidelines, or for the past twelve months does not exceed the annual guidelines and that the number listed for my household size is true and correct. Commodities are for my personal home use, not to be sold, traded, or given away.  **YES**  **NO**

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. 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**

Applicant's Printed Name	Applicant's Signature	Date
Applicant's Printed Name	Applicant's Signature	Date

### AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly or I will be terminated from the CSFP. In the event that I am unable to pick up my food boxes, please release them to:

<b>Proxy's Printed Name(s):</b>	<b>Proxy's Signature(s):</b>

## Commodity Supplemental Food Program (CSFP) Participant Rights and Responsibilities

1. Program standards are applied without discrimination by race, color, national origin, age, disability, or sex.
2. Applicants and participants have the right to appeal any decision made by the local agency regarding denial or termination of the CSFP through the fair hearing process. An appeal may be made verbally or in writing, and a request for a fair hearing may be arranged at the local agency headquarters office.
3. The local agency will make nutrition information available to participants, and to parents or guardians of infant and child participants and will encourage them to participate.
4. The local agency will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
5. Participants may not receive both CSFP and WIC benefits simultaneously and may not receive CSFP benefits more than once a month.
6. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the participant to recover the value of the benefits and may lead to the disqualification from the CSFP.
7. Participants must report changes in household income or composition within 10 days after the change becomes known to the household.

\*CSFP Racial/Ethnic Data Collection: This information is being requested to comply with the United States Department of Agriculture requirements governing the CSFP. The information requested is solely for the purpose of determining the State's compliance with the Federal civil rights laws. Your response will not affect consideration of your application or your participation in the CSFP and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner. If you decline to provide the requested ethnic/race information your race and ethnicity will be determined through visual observation and recorded in the data system.

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.

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](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 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 **email:** [program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.