COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

LAST NAME: _____ FIRST NAME: _____MIDDLE INITIAL: _____

MAILING ADDRESS: _____
City Zip

STREET ADDRESS: _____
(If Different) City Zip

COUNTY:_____ PHONE #: _____ DATE OF BIRTH: _____
(MM/DD/YYYY)

EMAIL (optional): _____

APPLICANTS MUST BE 60 YEARS OF AGE OR OLDER TO QUALIFY FOR CSFP

COMPLETE THIS SECTION FOR ALL OTHER PERSONS IN YOUR HOUSEHOLD:

LAST NAME, FIRST NAME	RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)

Household Size	Maximum **Monthly** Household Income	Maximum **Annual** Household Income
1	$1,383	$16,588
2	$1,868	$22,412
3	$2,353	$28,236
4	$2,839	$34,060
5	$3,324	$39,884
6	$3,809	$45,708
7	$4,295	$51,532
8	$4,780	$57,356
For each additional family member, add:	$486	$5,824

Income Definition:
Income is gross cash earned before any deductions.

Income Guidelines:
Maximum income levels are set at 130% of the Federal Poverty Income Guidelines, as shown in the table to the left.

Financial Situation Changes:
You are required to report any changes in household income to the CSFP distributing agency within 10 days of the change.

I hereby verify that I meet the income qualification guidelines and qualify to participate in the Commodity Supplemental Food Program.

☐ Yes, I meet income qualification guidelines to participate in CSFP
☐ No, I do not meet income qualification guidelines to participate in CSFP

Racial and Ethnic Data

Are you of Hispanic or Latino origin? ☐ 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

Racial and/or ethnic data collected on this form have no effect on the eligibility determination of the household. Thank you for filling out this form as accurately and completely as possible. The federal government is requesting this information in order to monitor compliance with the federal statutes that prohibit federally assisted programs from discriminating against applicants on this basis. Information obtained will be kept confidential and used for statistical analysis only.

AUTHORIZED REPRESENTATIVE (Proxy): You can authorize someone other than yourself to pick up your food commodities for you.

By signing this form, I hereby authorize (Name):_____
Phone Number: _____ to provide information to The Idaho Foodbank on my behalf regarding CSFP. I further authorize The Idaho Foodbank to access any records in order to verify information given.

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, or 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.

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 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

I hereby verify that I understand the No-Show policy and acknowledge that if I fail to pick up my CSFP box for 2 consecutive months, I will be discontinued from the program. ☐ Yes ☐ No

APPLICANT SIGNATURE: _____ DATE: _____

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, 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. This institution is an equal opportunity provider.

* * * * * **FOR DISTRIBUTING PARTNER AGENCY USE ONLY** * * * * *	
Identity Verified: ☐ Describe Proof:	Residency Verified: ☐
Distributing Partner Signature & Date: X_____ Date_____	Distributing Agency Name:

* * * * * **FOR LOCAL AGENCY (IFB) USE ONLY** * * * * *			
The Idaho Foodbank CSFP Coordinator Signature: X_____	Date Certified:	Added to Waitlist: Yes ☐ No ☐ Date:	Period of Certification: First Month: Last Month: