Polk County Supplemental Food Program
Senior Program

TO BE COMPLETED BY APPLICANT

Date_____

Name of Applicant_____

Address_____ Apt_____ City_____

County _____ State _____ Zip _____

Telephone (____)_____ Date of Birth _____/_____/_____ Sex _____M _____F

Do you need your food delivered? Yes _____ No _____ ***Note: Due to time constrains, delivery may be to a central location in your area and not directly to your door.**

If you marked YES for delivery, you are authorizing Polk County Supplemental Foods or a 3rd party vendor/contractor to deliver your food package to you. At time of delivery, you or a proxy must be present and show ID at each delivery. Food boxes will not be left for participants who are not home.

The Racial/Ethnic data is for statistical reporting purposes and has no effect on the determination of eligibility to participate in the program. Please list each household member separately along with their individual income. Total household members _____

Applicant_____ Income _____
Are you Hispanic or Latino? (Check one) _____ Yes _____ No Monthly_____ or Weekly _____
What is your race? (Check all that apply) SSA _____ SSI _____ Employed _____
_____American Indian or Alaska Native Other _____
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White

Household member_____ Income _____D.O.B_____
Are you Hispanic or Latino? (Check one) _____ Yes _____ No Monthly_____ or Weekly _____
What is your race? (Check all that apply) SSA _____ SSI _____ Employed _____
_____American Indian or Alaska Native Other _____
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White

PROXY

If there is someone you would like to add as a proxy to your file to allow them to pick up food for you, please fill out the following information and sign below. This permission will last until it is withdrawn by the applicant.

I authorize _____ to act as my representative (Proxy) in regards to picking up my commodity foods.

Signed: _____
Applicants signature

APPLICANT'S RIGHTS AND RESPONSIBILITIES

Failure to comply with the rules below may result in disqualification from participation in the Commodity Supplemental Food Program.

1. Program standards are applied without discrimination by race, color, national origin, age, sex or disability.
2. The local agency will provide notification of a decision to deny or terminate CSFP benefits and of an individual's right to appeal this decision by requesting a fair hearing.
3. The local agency will make nutrition education available to all 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. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits, and may lead to disqualification from CSFP.
6. Participants must report changes in household income or composition within 10 days after the change becomes known to the household.

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 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 agree that I have read, or was read to, the above certification statement.

Signature _____ Date _____

After completing the application and signing it, please fax to: 515-323-5296, or mail to: Polk County Supplemental Food Program, 2309 Euclid Ave, Des Moines, IA 50310. Please remember to send a copy of your ID; with your birthdate and name legible on it with your application. If you have questions, please call us at 286-3655 or toll free at 877-288-3655.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov