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 box delivered? _____Yes _____No

The Racial/Ethnic data is for statistical reporting purposes and has no affect on the determination of eligibility to participate in the program.

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

Total household members ______________ Household Income $_____________________ _____Weekly _____Monthly _____Yearly

List other household members, their birthdates and their relationship to the applicant ____

____

____

_____ SSA _____ SSI _____ Employed Employer Name ____ _____Other Income Source

Have you ever been on the Commodity Program (CSFP)? _____Yes _____No If yes, where?________________________________

PROXY

If there is someone you would like to add as a proxy to your file, please fill out the following information and sign below.

I authorize ____ to act as my representative (Proxy) in regard to picking up my commodity foods. They have my permission to pick up my food for the time period indicated:

_______ One time pick up for the month of _________________ 20____.

_______ For the month(s) of ___________________________________.

_______ Permanent, unless I inform you otherwise.

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 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

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 Ave, 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.