**SAMPLE**

**PARTICIPANT APPLICATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Household Information:** To be completed by the applicant or authorized representative | | | | | | | | | |
| **Applicant Name** (Last, First, Middle Initial): | | | | | **Phone Number**: | | | **Application Date**: | |
| **Street Address** (Include Apt # if applicable): | | | | | **City**: | **Zip:** | | **State**: | **County**: |
| **Date of Birth** (MM/DD/YY): | | | **Current Age**: | | **Total Household Gross Income**  (before deductions): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Annual  Monthly  Twice Per Month  Every 2 Weeks  Weekly  No Income | | | | |
| **Household Size** (Total number of household  members, including applicant): \_\_\_\_\_\_\_\_\_\_ | | | | |
| **CSFP Income Guidelines 2024 (150% of poverty rate)** | | | | | | | | | |
| I hereby certify that my household income is at or below the following guidelines.  Yes  No | | | | | | | | | |
| Household Size | Annual Income | | | Monthly Income | Twice Per Month | | Every Two Weeks | | Weekly Income |
| 1 | $22,590 | | | $1883 | $942 | | $870 | | $435 |
| 2 | $30,660 | | | $2,555 | $1,278 | | $1,180 | | $590 |
| 3 | $38,730 | | | $3,228 | $1,613 | | $1,490 | | $745 |
| 4 | $46,800 | | | $3,900 | $1,950 | | $1,800 | | $900 |
| 5 | $54,870 | | | $4,573 | $2,287 | | $2,112 | | $1056 |
| 6 | $62,940 | | | $5,245 | $2,623 | | $2,422 | | $1,211 |
| 7 | $71,010 | | | $5,918 | $2,959 | | $2,732 | | $1,366 |
| 8 | $79,080 | | | $6,590 | $3,295 | | $3,042 | | $1,521 |
| For each additional HH member, add: | $8,070 | | | $673 | $337 | | $312 | | $156 |
| **Ethnic/Racial Data:** For Statistical Purposes ONLY | | | | | | | | | |
| **Ethnic Category** (Select one):  Are you Hispanic or Latino?  Yes  No | | **Racial Category** (Select one or more):  American Indian or Alaska Native  Asian  Black or African  Native Hawaiian or Other Pacific Islander  White American  Prefer not to Disclose | | | | | | | |
| **Proxy Information:** A proxy is a person the applicant may authorize to pick up the CSFP food packages on their behalf for a specified time period. The proxy must be at least 18 years of age and must bring proof of his/her identification to pick up the CSFP food package. If you would like to designate a proxy, please complete the information below. | | | | | | | | | |
| **Name of Proxy** (Must be at least 18 years of age): | | | | | **Designated Time Period for  CSFP Food Pick Up** (Month/year): | | | | |

|  |
| --- |
| **OFFICIAL USE (Local Agency Staff/Volunteers)**  Eligibility Criteria:  Age  Income  County of Residence Applicant’s Identification was Confirmed  Verification Source(s) for Identification,  Age and County of Residence:  Driver’s License  State-Issued ID  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Document Name (If other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LA Staff/Volunteer Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LA Staff/Volunteer Staff’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

CONTINUE TO BACK

|  |  |  |  |
| --- | --- | --- | --- |
| **OFFICAL USE (To be completed by Local Agency Staff Only)** | | | |
| **Status:**  Eligible (Active List)  Eligible (Waiting List) | **Method of Notification:**  Verbal  Letter | | **Date of Notification:** |
| **Initial Certification Period:**  From \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_ | **Re-Certification Period:**  1. From \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_  2. From \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_ | | **Re-Certification Dates of Notification**  1. \_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_ |
| **If applicable: Date Certified as Active from Wait List:** |
| **Status:**  Ineligible  Discontinued  Disqualified  Terminated | | **Date of Written Notification:** | |
| **Ineligible/Discontinued/Disqualified/Terminated-Reason:** | | | |
| **LA Staff’s Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **LA Staff’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Determination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| 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/ad-3027.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](mailto:program.intake@usda.gov)   THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER. | | | |
| **Certification**: 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 | | | |
| **Signature of Applicant/Authorized Representative (Circle One): Date:** | | | |

**APPLICATION** **INSTRUCTIONS: Complete application in black or blue ink only.**

|  |
| --- |
| **To Be Completed by the Applicant or Authorized Representative** |

Applicant Name List applicant’s last name, first name and middle initial.

Telephone Number List applicant’s area code and telephone number.

Application Date: List the date of application.

Street Address List applicant’s street address and if applicable, apartment number.

City List applicant’s city of residence.

Zip Code List applicant’s zip code.

County List the applicant’s county of residence.

Date of Birth List applicant’s month, day and year of birth.

Current Age List applicant’s age.

Total Household Gross Income List the total household gross income (before deductions) and check the box for

and How Often is Received how often income is received (i.e., weekly, monthly, etc.). If no one in the household receives income, check the No Income box.

Household Size List the total number of household members, including applicant.

Income Certification Check either Yes or No to certify the household income is within the allowable guideline limits. Check Yes, if applicant cannot provide proof of income and self declares that their household income is below 130% of the current income poverty guidelines.

Ethnic & Racial Data This question is optional for the applicant. Please select one Ethnicity, then select one or more Race categories. Applicant may also select “Prefer not to disclose”.

Proxy Complete only if authorizing an individual to obtain the CSFP food kits on the applicant’s behalf. Provide the proxy’s name and the time period in which the applicant designates the individual as a proxy.

Certification Statement Read the certification statement and check either Yes or No.

Signature of Applicant/ The person for whom CSFP benefits are being requested must sign the application. If the

Authorized Representative application is being made by an authorized representative, the authorized representative may sign on behalf of the applicant.

Signature Date List the date the application is signed.

|  |
| --- |
| **Official Use - To Be Completed by Local Agency Site Staff/Volunteer Only** |

Eligibility Criteria/ Once the applicant’s eligibility criteria and identification have been verified/confirmed,

Applicant Identification check all applicable boxes. If any box cannot be checked as applicable, the applicant is not eligible for participation.

Verification Source(s) Check the applicable box(s) for the verification source(s) used to verify/confirm the applicant’s identification, age and county of residence (i.e., driver’s license, State-issued ID, etc.). If Other is checked, list the document name (i.e. passport, birth certificate, Medicare Card, etc.). A Social Security card is not an acceptable source of verification.

LA Staff/Volunteer Printed Name Print the name of the designated Local Agency staff/volunteer verifying the information on the application.

LA Staff/Volunteer Signature/Date Provide the signature of the designated Local Agency staff/volunteerand date the application is received or taken.

|  |
| --- |
| **Official Use - To Be Completed by Local Agency Staff Only** |

Status - Eligible Active, Waiting List Check the applicable box.

Method of Notification/Date Check the applicable box and provide the date of notification.

Initial Certification Period Provide the date of the original certification period.

Re-Certification Period/Date If applicable, provide the re-certification period and the date the applicant was notified of their re-certification.

Date Certified as Active from Waiting List If applicable, provide the date the participant was certified as Active from the Waiting list.

Status- Ineligible/Discontinued, Check the applicable box and provide the date the written notification was provided.

Disqualified, Terminated - Reason/Date

LA Staff Printed Name/Title Print Name and title of LA Staff.

LA Staff Signature/Date The LA Staff making the eligibility/ineligibility determination must sign and provide the date the eligibility/ineligibility determination was made.