

To apply for the Commodity Supplemental Food Program please fill out and return the following:

- Application
- Universal Intake Form
- Copy of identification showing Date of Birth Picture ID or Birth Cert.
   OR the Affidavit Attesting Age. Must be signed
- Copy of your household income either a bank statement or a copy of SS letter

Thank you for your participation in this program. If you have any questions, please feel free to contact Bonnie at 701-232-2452.

SENDCAA 3233 South University Drive Fargo, ND 58104



Commodity Supplemental Food Program Application NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION Child Nutrition and Food Distribution Programs Commodity Supplemental Food Program (CSFP) Revised (6/15)

Name		Address	3					
City	State	County	1	Γelephor	ne Number			
Home delivery: Pick up: Directions for home delivery, if needed:								
1. Are you Hispanic or Latino?	☐ Yes ☐ No							
2. What is your race? (Select one	e or more):							
☐ American Indian or Alaska N☐ Native Hawaiian or Other Pa			ack or African	ı America	an;			
Household M (List ALL household		Date of Birth		Form of ID Presented by the applicant*				
				:				
* DL=Drivers License, BC=Birth Certifi	cate, OT=Other (Spec	ify), NA=N	ot Available (Si	gned Affi	davit Attesting Age)			
This must be read to or read by the applicant:  This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that it is illegal to participate in the CSFP at more than one local agency and to make false or misleading statements, misrepresent, conceal or withhold facts regarding my household income. I am also aware that as a result, I could be disqualified from the program for a period not to exceed 3 months. 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 Signature			Date					
Caseworker/Program Director Sig		Date						

A	pplicant's Right and Responsibilities
•	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;
•	The local agency will make nutrition education available to participants and will encourage them to
	participate;

- The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate;
- Participants must report changes in household income or composition within 10 days after the change becomes known to the household.

## Income Verification:

Elderly persons (aged 60 years or older) are income-eligible for CSFP if their <u>gross income</u> is at or below 130% of federal poverty thresholds. Income means <u>gross income</u> before deductions for such items as income taxes, employees' social security taxes, insurance premiums, and bonds.

Document all household income below. If available, provide income documentation to the case worker along with the application. Proof of income is not required.

along with the application. I roof of friconic is not required.											
All Household	Wages	Social Security/	Public	Self	Other	Subtotals					
Members	_	Retirement/	Assistance	Employment/							
		Pension	7 10010101100								
		rension		Unemployment							
						1					
	•										
			The Part of the Control of the Contr								
***************************************	C										
Total Household											
						\$					
Income:						•					

For Office Use Only:		
Maximum income for a household of is \$	Certification period:	to
If more than one person in the household, list member(s) eligible	e and <u>number of food packs desired</u> :	
If more than one person in the household, list member(s) NOT e receive Commodity Supplemental foods:	ligible to	
Re- certification period to		
Re-certification Approved by:  Caseworker/Program Director S	Date: Signature	- National and

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If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at <a href="http://www.ascr.usda.gov/complaint\_filing\_cust.html">http://www.ascr.usda.gov/complaint\_filing\_cust.html</a>, or at any USDA office, or call (866)632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a>. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800)845-6136 (Spanish). USDA is an equal opportunity provider and employer.



## Household Demographic Form

Date First Name	First Name M.I. Last Name								
Birthdate Age		Social Security Number				Gender			
						□Male □ Female □ Other			
Are you disabled? U.S Militar	у	1		What is your	Ethnicity?		How many i	n the I	Household?
☐ Yes ☐ No ☐ Active	<b>□</b> Veteran	☐ Nor	ne Military	☐ Hispanic	☐ No	n-Hispanic			
What is your primary race?		What is	your highes	t level of	What is yo	ur medical cover	age?		
🗖 American Indian / Alaska Nativ	e	education?			☐ Medicaid				
☐ Asian					■ Medica				
☐ Black / African American		_				n's Health Insurai	nce Program	n (CHIF	P) North Dakota
☐ Native Hawaiian / Other Pacific	: Islander	_	rad/GED	_	Healthy St		0 - 0		
☐ White		_	rade + some	Post-		Health Care (De			
Other:	\ \	Second	•			urchase (Health	_		
☐ Multi-race (two or more of the	above)		4 years cond duate of othe	_	☐ None	ment Based (Insu	irance provi	aea b	y employer)
☐ Unknown		Second		er Post-	☐ Other				
What is your family type?		What is	your curren	t housing situa	ation?	Work Status?			
☐ Single Person		☐ Own	ı			☐ Employed Full Time			
☐ Single Parent Female		☐ Rent	-			☐ Employed Part Time			
☐ Single Parent Male		☐ Othe	er Permanen	it housing		☐ Migrant Seasonal Farm Worker			r
☐ Two Adults. No Children		☐ Homeless				☐ Unemployed(Short Term, 6 months or less)			
☐ Two Parent Household		☐ Other			☐ Unemployed(Long Term, more than 6 months)				
☐ Non-related Adults with Childre	en	☐ Unknown				☐ Unemployed (Not in Labor Force)			ce)
☐ Multigenerational Household						☐ Retired			
☐ Other:			1		Γ.			1	
Mailing Address			City		State	Zip Code		Count	ty
Daine and Dhama North and			C	Dhana Numaha	ND	Frankl Address.			
Primary Phone Number:			Secondary	Phone Numbe	r:	Email Address:			
What income do you received?	How mu	ch? H	ow often?	What Benefit	s do you re	ceive?	How muc	h?	How often?
☐ Employment	\$			☐ SNAP			\$		
☐ Social Security	\$			□ WIC			\$		
□ SSI	\$			☐ LIHEAP			\$		
□ SSDI	\$			☐ Housing Choice Voucher (Section		her (Section 8)	\$		
☐ VA Service-Connected	\$			☐ Public Housing			\$		
☐ VA Non-Service Connected	\$			☐ Permanent Supportive Housing		\$			
☐ Child Support	\$			☐ HUD-VASH			\$		
☐ Alimony / Spousal Support	\$			☐ Childcare Voucher		\$			
☐ TANF	\$			☐ Affordable Care Act Subsidy		\$			
☐ Pension / Retirement	\$			☐ Other:			\$		
☐ Worker's Compensation	\$			☐ Unknown					
☐ Unemployment	\$								
☐ Other:	\$		☐ I have no income			his time (initial he	ere):		

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

10/2017

First Name	MI Last Name			Relationship to Head of Household			
Birthdate	Age	Social Security Number		Gender			
/					☐Male ☐ Female ☐ Other		
Are you disabled?		U.S Military			What is your Ethnicity?		
☐ Yes ☐ No		☐ Active ☐ Veteran ☐ None Military			☐ Hispanic ☐ Non-Hispanic		
What is your primary race?		Wha	at is your highes	st level of education?	What is your m	edical coverage?	
☐ American Indian / Alaska Nativ	ve		)-8 <sup>th</sup>		☐ Medicaid		
☐ Asian		<b>1</b> 9	<sup>th</sup> -12 <sup>th</sup> non-grad	d	☐ Medicare		
☐ Black / African American			IS grad/GED		☐ Children's Health Insurance Program (ND		
☐ Native Hawaiian / Other Pacifi	c Islander		.2 grade + some	Post-Secondary	Healthy Steps)		
☐ White		<b>□</b> 2	or 4 years Coll	ege Graduate	☐ Military Hea	lth Care (Dept o	f Defense, VA)
☐ Other			Graduate of oth	er Post-Secondary	☐ Direct Purch	ase (Health Exch	nange or ACA)
☐ Multi-race (two or more of the	e above)				☐ Employment	t Based (through	employer)
☐ Unknown					☐ Other		
What income do you received?	How much	า?	How often?	What income do you re		How much?	How often?
☐ Employment	\$		\$	☐ Alimony / Spousal Su	ıpport	\$	\$
☐ Social Security	\$		\$	☐ TANF		\$	\$
□ SSI	\$		\$	☐ Private Disability Inst	urance	\$	\$
□ SSDI	\$		\$	☐ Pension / Retirement		\$	\$
☐ VA Service-Connected	\$		\$	☐ Worker's Compensat	tion	\$	\$
☐ VA Non-Service Connected	\$		\$	☐ Unemployment		\$	\$
☐ Child Support	\$		\$	☐ Other:		\$	\$
Additional Household Members  First Name MI Last Name Relationship to Head of Household						old	
Birthdate	Age		Social Security	v Number	Gender		
/ /	VRC		-	y Number	☐Male ☐ Fer	male <b>П</b> Other	
Are you disabled?		115	 Military		What is your Ethnicity?		
☐ Yes ☐ No			•	an 🗖 None Military	· ·	□ Non-Hispa	nic
What is your primary race?			/ Vhat is your highest level of education?		What is your medical coverage?		
☐ American Indian / Alaska Nativ	re	0-8 <sup>th</sup>		☐ Medicaid			
, Asian		☐ 9 <sup>th</sup> -12 <sup>th</sup> non-grad		☐ Medicare			
☐ Black / African American		☐ HS grad/GED		☐ Children's Health Insurance Program (ND			
☐ Native Hawaiian / Other Pacifi	c Islander		☐ 12 grade + some Post-Secondary		Healthy Steps)		
☐ White		<b>1</b> 2	2 or 4 years College Graduate		☐ Military Health Care (Dept of Defense, VA)		
☐ Other			Graduate of oth	er Post-Secondary	☐ Direct Purchase (Health Exchange or ACA)		
☐ Multi-race (two or more of the	above)				☐ Employment Based (through employer)		
☐ Unknown					☐ Other		
What income do you received?	How much	า?	How often?	What income do you re	ceived?	How much?	How often?
☐ Employment	\$		\$	☐ Alimony / Spousal Su	ıpport	\$	\$
☐ Social Security	\$		\$	☐ TANF		\$	\$
□ SSI	\$		\$	☐ Private Disability Insu	urance	\$	\$
□ SSDI	\$		\$	☐ Pension / Retiremen	t	\$	\$
☐ VA Service-Connected	\$		\$	☐ Worker's Compensat	tion	\$	\$
☐ VA Non-Service Connected	\$		\$	☐ Unemployment		\$	\$
☐ Child Support	\$		\$	☐ Other:		\$	\$

Additional Household Members

2 10/2017



## **Commodity Supplemental Food Program Affidavit Attesting Age**

(Revised 8/2010)

Name:	
Address:	
I,, am applying for (Applicant)	or the Commodity Supplemental
Food Program with SENDCA (Name of local ag	
I understand that I have been asked to pram unable to provide such information. age, to participate in the Commodity Sup	rovide some form of identification to prove my age, but I attest that I am 60 years or older and that I qualify, by oplemental Food Program.
? '	
Applicant Signature	Applicant's Date of Birth
Certification Supervisor	Date

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