SOUTHEASTERN NORTH DAKOTA community Action

NORTH DAKOTA'S POVERTY FIGHTING NETWORK

Helping People Changing Lives

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 Certificate OR the Affidavit Attesting Age. Must be signed.
- Copy of your household income-either a bank statement or a copy of SS letter.
- Proxy Form-if you need someone else, other than you to pick up your commodities for you.

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

SENDCAA

3233 University Drive South

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 (10/2019)

Name		Address	
City	State	County	Telephone 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 or more):

☐ American Indian or Alaska Native; ☐ Asian; ☐ Black or African American;

☐ Native Hawaiian or Other Pacific Islander; ☐ White

Household Members (List ALL household members)	Date of Birth	Form of ID Presented by the applicant*

*** DL=Drivers License, BC=Birth Certificate, OT=Other (Specify), NA=Not Available (Signed Affidavit 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 12 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 Signature	Date

Applicant'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 gross income is at or below 130% of federal poverty thresholds. Income means gross income 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.

All Household Members	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment/ Unemployment	Other	Subtotals
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 and number of food packs desired:

_____

If more than one person in the household, list member(s) NOT eligible to receive Commodity Supplemental foods:

_____

"This institution is an equal opportunity provider."

Household Demographic Form

Date	First Name	M.I.	Last Name

Birthdate	Age	Social Security Number	Gender
___/___/_____		_____-_____-_____	☐Male ☐ Female ☐ Other

Are you disabled?	U.S Military	What is your Ethnicity?	How many in the Household?
☐ Yes ☐ No	☐ Active ☐ Veteran ☐ None Military	☐ Hispanic ☐ Non-Hispanic	

What is your primary race?	What is your highest level of education?	What is your medical coverage?
☐ American Indian / Alaska Native	☐ 0-8th	☐ Medicaid
☐ Asian	☐ 9th-12th non-grad	☐ Medicare
☐ Black / African American	☐ HS grad/GED	☐ Children's Health Insurance Program (CHIP) North Dakota Healthy Steps)
☐ Native Hawaiian / Other Pacific Islander	☐ 12 grade + some Post-Secondary	☐ Military Health Care (Dept. of Defense, VA)
☐ White	☐ 2 or 4 years College Graduate	☐ Direct Purchase (Health Exchange or ACA)
☐ Other:_____	☐ Graduate of other Post-Secondary	☐ Employment Based (Insurance through employer)
☐ Multi-race (two or more of the above)		☐ None
☐ Unknown		☐ Other

What is your family type?	What is your current housing situation?	Work Status?
☐ Single Person	☐ Own	☐ Employed Full Time
☐ Single Parent Female	☐ Rent	☐ Employed Part Time
☐ Single Parent Male	☐ Other Permanent housing	☐ Migrant Seasonal Farm Worker
☐ 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 Children	☐ Unknown	☐ Unemployed (Not in Labor Force)
☐ Multigenerational Household		☐ Retired
☐ Other: _____		

Mailing Address	City	State	Zip Code	County
		ND		

Primary Phone Number:	Secondary Phone Number:	Email Address:

What Income do you received?	How much?	How often?	What Benefits do you receive?	How much?	How often?
☐ Employment	$		☐ SNAP	$	
☐ Social Security	$		☐ WIC	$	
☐ SSI	$		☐ LIHEAP	$	
☐ SSDI	$		☐ Housing Choice Voucher (Section 8)	$	
☐ VA Service-Connected	$		☐ Public Housing	$	
☐ VA Non-Service Connected	$		☐ Permanent Supportive Housing	$	
☐ Child Support	$		☐ HUD-VASH	$	
☐ Allmony / Spousal Support	$		☐ Childcare Voucher	$	
☐ TANF	$		☐ Affordable Care Act Subsidy	$	
☐ Worker's Compensation	$		☐ Other:_____	$	
☐ Unemployment	$		☐ Unknown		
☐ Other:_____	$		☐ I have no income at this time (Initial here):_____		

You certify that the information you have disclosed is correct and complete to the best of your knowledge. You understand that failure to provide the needed documentation or knowingly providing false information will result in denial of assistance and your case will be closed due to fraud. All information provided will be kept in the strictest of confidence. You agree to sign this form at your own will. Your file may be monitored by state agencies for funding and quality review purposes

Applicant Signature:_____ Date:_____

SOUTHEASTERN NORTH DAKOTA community Action
NORTH DAKOTA'S POVERTY FIGHTING NETWORK
Helping People. Changing Lives.

Commodity Supplemental Food Program
Affidavit Attesting Age
(Revised 7-2021)

Applicant Name:	Address:

I, _____ , am applying for the Commodity Supplemental
(Applicant)

Food Program with _____.
(Name of local agency)

I understand that I have been asked to provide some form of identification to prove my age, but am unable to provide such information. I attest that I am 60 years or older and that I qualify, by age, to participate in the Commodity Supplemental Food Program.

_____ _____
Applicant Signature Applicant's Date of Birth

_____ _____
Local Agency Representative 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: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, 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.

SOUTHEASTERN NORTH DAKOTA community Action
NORTH DAKOTA'S POVERTY FIGHTING NETWORK
Helping People. Changing Lives.

Commodity Supplemental Food Program Designation for Proxy

(Revised 7-2021)

Applicant Name:	Address:	Date:

I, _____ , designate _____ to act as a proxy for certification of the Commodity Supplemental Food Program application. If necessary, the proxy is also designated to pick up the food package on my behalf.

This consent shall remain from: _____ to _____.

_____ _____

Applicant Signature Proxy Signature

_____ _____

Local Agency Representative (Print) Local Agency Approval (Sign/Initial)

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: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, 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.