

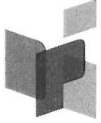
Senior citizens who are 60 and older may qualify for the Commodity Supplemental Food Program. If you are interested in applying please complete the following and return:

- Application
- Household Demographic Form
- Proof of Identity - Copy of ID, Birth certificate or completing the Affidavit Attesting Age
- Copy of Household Income (bank statement, Social Security letter, paystubs, etc.)

Thank you for your interest in the Commodity Program. If you any questions, please contact Hannah, Chanon or Bonnie at 701-232-2452.

Please return completed applications to

SENDCAA
3233 South University Drive
Fargo, ND 58104-6221



COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)
SFN 62427 (01-2024)

Applicant's First Name		Last Name	
Address		City	ZIP Code
County		Telephone Number	
Date of Birth (mm/dd/yyyy)		Preferred Method <input type="checkbox"/> Home Delivery <input type="checkbox"/> Pick Up	
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Not Latino			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White			
Household Members (other than self)		Date of Birth (mm/dd/yyyy)	CSFP Eligible (Yes/No)

Household Gross Monthly Income Information:

Earned Wages	SS	SSI	Public Assistance	Self-Employment
Pension	VA	Other	Total Household Size	Total Monthly Income
				\$ 0.00

Age Verification/Attestation:

Required Identification Verified (copy of identification with case file if available):				
<input type="checkbox"/> Drivers's License	<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> State ID	<input type="checkbox"/> Tribal ID	
<input type="checkbox"/> Attest applicant's age is 60 or over				

Proxy Identification:

The following individuals are authorized to act as my representative or take receipt of my food pack for CSFP:		
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Applicant's Rights 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.

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

Signature of Applicant	Date (mm/dd/yyyy)
Signature of Certifier	Date (mm/dd/yyyy)

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



Household Demographic Form

Date		First Name, M.I., Last Name					
Birthdate ____/____/____		Age		Social Security Number ____-____-____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military			Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many in the Household?
What is your primary race? <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-race (two or more of the above) <input type="checkbox"/> Unknown			What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary			What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> ND Healthy Steps <input type="checkbox"/> Military Health Care (VA) <input type="checkbox"/> Direct Purchase (ACA/Marketplace) <input type="checkbox"/> Employer Insurance <input type="checkbox"/> None <input type="checkbox"/> Other	
What is your family type? <input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Two Adults. No Children <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Non-related Adults with Children <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Other: _____			What is your current housing situation? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other Permanent housing <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Work Status? <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (Short Term, 6 months or less) <input type="checkbox"/> Unemployed (Long Term, more than 6 months) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired	
Mailing Address				City	State ND	Zip Code	County
Primary Phone Number:				Secondary Phone Number:		Email Address:	
What INCOME do you receive?		How much?	How often?	What BENEFITS do you receive?		How much?	How often?
<input type="checkbox"/> I have no income at this time				<input type="checkbox"/> Affordable Care Act Subsidy		\$	
<input type="checkbox"/> Employment		\$		<input type="checkbox"/> Childcare Voucher		\$	
<input type="checkbox"/> Social Security		\$		<input type="checkbox"/> Housing Choice Voucher (Section 8)		\$	
<input type="checkbox"/> SSI		\$		<input type="checkbox"/> HUD-VASH		\$	
<input type="checkbox"/> SSDI		\$		<input type="checkbox"/> LIHEAP		\$	
<input type="checkbox"/> VA Service-Connected		\$		<input type="checkbox"/> Public Housing		\$	
<input type="checkbox"/> Child Support		\$		<input type="checkbox"/> SNAP		\$	
<input type="checkbox"/> Alimony/Spousal		\$		<input type="checkbox"/> WIC		\$	
<input type="checkbox"/> TANF		\$		<input type="checkbox"/> Other: _____		\$	
<input type="checkbox"/> Worker's Compensation		\$		<input type="checkbox"/> None			
<input type="checkbox"/> Unemployment		\$					
<input type="checkbox"/> Other:		\$					

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: _____

Additional Household Members					
First Name MI Last Name			Relationship to Head of Household		
Birthdate ____/____/____	Age	Social Security Number ____-____-____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
What is your primary race? <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Multi-race (two or more of the above)		What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> ND Healthy Steps <input type="checkbox"/> Military Health Care (Dept of Defense, VA) <input type="checkbox"/> Direct Purchase (Health Exchange or ACA) <input type="checkbox"/> Employment Based (through employer) <input type="checkbox"/> Other	
What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	\$			\$	
Additional Household Members					
First Name MI Last Name			Relationship to Head of Household		
Birthdate ____/____/____	Age	Social Security Number ____-____-____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
What is your primary race? <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Multi-race (two or more of the above)		What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> ND Healthy Steps <input type="checkbox"/> Military Health Care (Dept of Defense, VA) <input type="checkbox"/> Direct Purchase (Health Exchange or ACA) <input type="checkbox"/> Employment Based (through employer) <input type="checkbox"/> Other	
What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	\$			\$	
Additional Household Members					
First Name MI Last Name			Relationship to Head of Household		
Birthdate ____/____/____	Age	Social Security Number ____-____-____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S Military <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None Military		What is your Ethnicity? <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
What is your primary race? <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Multi-race (two or more of the above)		What is your highest level of education? <input type="checkbox"/> 0-8 th <input type="checkbox"/> 9 th -12 th non-grad <input type="checkbox"/> HS grad/GED <input type="checkbox"/> 12 grade + some Post-Secondary <input type="checkbox"/> 2 or 4 years College Graduate <input type="checkbox"/> Graduate of other Post-Secondary		What is your medical coverage? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> ND Healthy Steps <input type="checkbox"/> Military Health Care (Dept of Defense, VA) <input type="checkbox"/> Direct Purchase (Health Exchange or ACA) <input type="checkbox"/> Employment Based (through employer) <input type="checkbox"/> Other	
What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	\$			\$	

Commodity Supplemental Food Program Designation for Proxy

(Revised 3/2026)

Client Name:	Date:
Proxy Name(s): (List the first and last names of all proxies requested)	

The client requests that the above-mentioned proxy or proxies are designated to pick up the food package on the client's behalf. If requesting certification or signature rights, a copy of the power of attorney must be provided to the local agency before approval.

This consent shall remain from the date of approval indefinitely until changed by the client.

Local Agency Representative (Name):	Date:
Signature:	Approval: <input type="checkbox"/> Yes <input type="checkbox"/> No

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027 (PDF), found online at 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:

mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW, Mail Stop 9410
Washington, D.C. 20250-9410

fax:
202-690-7442; or

email:
Program.Intake@usda.gov.

This institution is an equal opportunity provider.

