SENDCAA
SOUTHEASTERN NORTH DAKOTA COMMUNITY ACTION AGENCY

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 Cate, 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 SUPPLIMENTAL 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 ☐ Home Delivery ☐ Pick Up	

Ethnicity

☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

Race

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ 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):

☐ Drivers's License ☐ Birth Certificate ☐ State ID ☐ Tribal ID

☐ 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

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

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

What is your primary race?	What is your highest level of education?	What is your medical coverage?
☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other:_____ ☐ Multi-race (two or more of the above) ☐ Unknown	☐ 0-8th ☐ 9th-12th non-grad ☐ HS grad/GED ☐ 12 grade + some Post-Secondary ☐ 2 or 4 years College Graduate ☐ Graduate of other Post-Secondary	☐ Medicaid ☐ Medicare ☐ ND Healthy Steps ☐ Military Health Care (VA) ☐ Direct Purchase (ACA/Marketplace) ☐ Employer Insurance ☐ None ☐ Other

What is your family type?	What is your current housing situation?	Work Status?
☐ Single Person ☐ Single Parent Female ☐ Single Parent Male ☐ Two Adults. No Children ☐ Two Parent Household ☐ Non-related Adults with Children ☐ Multigenerational Household ☐ Other: _____	☐ Own ☐ Rent ☐ Other Permanent housing ☐ Homeless ☐ Other ☐ Unknown	☐ Employed Full Time ☐ Employed Part Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed(Short Term, 6 months or less) ☐ Unemployed(Long Term, more than 6 months) ☐ Unemployed (Not in Labor Force) ☐ 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?
☐ I have no income at this time			
☐ Employment	$		
☐ Social Security	$		
☐ SSI	$		
☐ SSDI	$		
☐ VA Service-Connected	$		
☐ Child Support	$		
☐ Alimony/Spousal	$		
☐ TANF	$		
☐ Worker's Compensation	$		
☐ Unemployment	$		
☐ Other:	$		

What BENEFITS do you receive?		How much?	How often?
☐ Affordable Care Act Subsidy	$		
☐ Childcare Voucher	$		
☐ Housing Choice Voucher (Section 8)	$		
☐ HUD-VASH	$		
☐ LIHEAP	$		
☐ Public Housing	$		
☐ SNAP	$		
☐ WIC	$		
☐ Other:_____	$		
☐ None			

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** ☐Male ☐ Female ☐Other

Are you disabled?
☐ Yes ☐ No

U.S Military
☐ Active ☐ Veteran ☐ None Military

What is your Ethnicity?
☐ Hispanic ☐ Non-Hispanic

What is your primary race?
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Multi-race (two or more of the above)

What is your highest level of education?
- ☐ 0-8th
- ☐ 9th-12th non-grad
- ☐ HS grad/GED
- ☐ 12 grade + some Post-Secondary
- ☐ 2 or 4 years College Graduate
- ☐ Graduate of other Post-Secondary

What is your medical coverage?
- ☐ Medicaid
- ☐ Medicare
- ☐ ND Healthy Steps
- ☐ Military Health Care (Dept of Defense, VA)
- ☐ Direct Purchase (Health Exchange or ACA)
- ☐ Employment Based (through employer)
- ☐ 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** ☐Male ☐ Female ☐Other

Are you disabled?
☐ Yes ☐ No

U.S Military
☐ Active ☐ Veteran ☐ None Military

What is your Ethnicity?
☐ Hispanic ☐ Non-Hispanic

What is your primary race?
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Multi-race (two or more of the above)

What is your highest level of education?
- ☐ 0-8th
- ☐ 9th-12th non-grad
- ☐ HS grad/GED
- ☐ 12 grade + some Post-Secondary
- ☐ 2 or 4 years College Graduate
- ☐ Graduate of other Post-Secondary

What is your medical coverage?
- ☐ Medicaid
- ☐ Medicare
- ☐ ND Healthy Steps
- ☐ Military Health Care (Dept of Defense, VA)
- ☐ Direct Purchase (Health Exchange or ACA)
- ☐ Employment Based (through employer)
- ☐ 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** ☐Male ☐ Female ☐Other

Are you disabled?
☐ Yes ☐ No

U.S Military
☐ Active ☐ Veteran ☐ None Military

What is your Ethnicity?
☐ Hispanic ☐ Non-Hispanic

What is your primary race?
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Multi-race (two or more of the above)

What is your highest level of education?
- ☐ 0-8th
- ☐ 9th-12th non-grad
- ☐ HS grad/GED
- ☐ 12 grade + some Post-Secondary
- ☐ 2 or 4 years College Graduate
- ☐ Graduate of other Post-Secondary

What is your medical coverage?
- ☐ Medicaid
- ☐ Medicare
- ☐ ND Healthy Steps
- ☐ Military Health Care (Dept of Defense, VA)
- ☐ Direct Purchase (Health Exchange or ACA)
- ☐ Employment Based (through employer)
- ☐ Other

What INCOME do you receive?	How much?	How often?	What BENEFITS do you receive?	How much?	How often?
	$			$	

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

Commodity Supplemental Food Program
Affidavit Attesting Age
(Revised 5/2022)

Applicant Name:	Address:

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

Food Program with SENDCAA .
(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, 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/USDA-OASCR%20P-Complaint-Form-0508https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf0002-508-11-28-17Fax2Mail.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