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 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 (6/13)

Name		Address	
City	State	County	Telephone Number
Home delivery: ☐ Pick up: ☐		Directions for home delivery, if needed:	

Participation Category (Please check one):

☐ Elderly (60 + years) ☐ Breastfeeding Woman ☐ Child (0-6 years) ☐ Post-Partum Woman

It is illegal to participate in the CSFP at more than one local agency, or to participate simultaneously in the CSFP and the WIC program. If you participate in both programs simultaneously or make false or misleading statements, misrepresent, conceal or withhold facts regarding your income, you may be disqualified from both programs for a period not to exceed 3 months.

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 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 both CSFP and WIC benefits simultaneously, and 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 [ ]

Applicant Signature	**Date**
Caseworker/Program Director Signature	**Date**

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of the individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html , 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 program.intake@usda.gov .

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.

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 all adult participants, and to parents or caretakers of infant and child 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;
- The improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits, and may lead to disqualification from CSFP; and
- 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. ***Proof of income is NOT required. If income documentation is available, it must be documented on the application and filed with the client file. If not available, then document income based on verbal confirmation by the applicant on the application.***

Determination of Income:

Monthly Income is determined as follows:
Weekly Income (x) 4.3
Bi-weekly Income (x) 2.15)
Semi-monthly Income (2 times per month) (x) 2
Monthly income (1 time per month)

Household Members	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment	Unemployment	Other
Total Household Income:						

Total adjusted income from all sources: **$**_____ **or SD if income documentation is not available.**

Maximum income for a household of _____ **is $** _____

Certification period: _____ to _____

List the name(s) of household member(s) eligible to receive Commodity Supplemental foods and number of food packs desired:

_____

List the name(s) of household member(s) NOT eligible to receive Commodity Supplemental foods:

_____

Re- certification period _____ to _____

Re-certification Approved by:_____ Date:_____
Certification Supervisor

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Commodity Supplemental Food Program Affidavit Attesting Age

(Revised 8/2010)

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

_____ _____
Certification Supervisor Date

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S. W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

SENDCAA **CLIENT HOUSEHOLD INTAKE**

Intake Date: ____/____/____

Program:_____

HEAD OF HOUSEHOLD INFORMATION

_____ _____ _____ _____/_____/_____
First Middle Last Social security number

_____ _____ _____
Mailing address City Zip code

_____ _____ _____ _____
Physical address (if different from above) County Home phone number Mobile/cell phone

Email Address: _____

Household Type:
___ Single Parent Female ___ Single Parent Male ___ Two Parent Household
___ Single Person ___ Two Adults, no children ___ Other _____

Household Size: _____

Birth Date: _____ **Gender:** Male Female

Race: ___ White ___ Asian ___ Black ___ Multi ___ American Indian ___ Other

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino

Education: ___ 0 to 8th grade ___ 9 to 12 grade (non grad) ___ high school grad/GED ___ 12+ post secondary ___ College Degree (2yr or 4yr)

Medical Coverage: ___ Medicare ___ Medicaid ___ Private Insurance ___ Indian Health Service ___ Other _____ ___ None

Veteran: yes no **Disabled**: yes no **Farmer**: yes no

Gross Income Per Month (head of household member):

Employment	$_____	TANF	$_____	Other	$_____
Unemployment	$_____	General Assistance	$_____	describe if other:	_____
Social Security	$_____	Pension	$_____		
SSI/SSDI	$_____	Child Support	$_____		

_____ **No Income** **Household HHS Income Level:** _____ **(staff use only)**

Food Stamps: no yes **If yes, amount: $**_____ **Fuel Assistance**: yes no

Housing Status:
____ Owner ____ Homeless with roof ____ Other_____
____ Renter ____ Homeless no roof

Rent/Mortgage Amount: $_____ **Rental Assistance**: yes no

I hereby certify that the information provided in this document is true and complete to the best of my knowledge. I understand that benefits received based on false information must be repaid and could result in a fine, imprisonment or both.

Applicant signature: _____ Date: _____

Other Household Members

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

disabled: yes no **education level**:________ **medical coverage**: medicaid medicare private ins. IHS other none

monthly income amount: $_____employment $_____unemployment $_____Soc. Sec. $_____SSI/SSDI $_____TANF
$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

disabled: yes no **education level**:________ **medical coverage**: medicaid medicare private ins. IHS other none

monthly income amount: $_____employment $_____unemployment $_____Soc. Sec. $_____SSI/SSDI $_____TANF
$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

disabled: yes no **education level**:________ **medical coverage**: medicaid medicare private ins. IHS other none

monthly income amount: $_____employment $_____unemployment $_____Soc. Sec. $_____SSI/SSDI $_____TANF
$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

disabled: yes no **education level**:________ **medical coverage**: medicaid medicare private ins. IHS other none

monthly income amount: $_____employment $_____unemployment $_____Soc. Sec. $_____SSI/SSDI $_____TANF
$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

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$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______

______________ ______ ______________ _____/_____/_____ ______________
First name middle last name social security relation to applicant
Birth date:__________ **gender**: male female **race**:__________ **ethnicity**: hispanic not hispanic **veteran:** yes no

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$_____Gen.Assist. $_____child support $_____pension $_____Other______________
no income: _______ **Food stamps:** no yes, if yes – amount:$_______