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 (6/15)

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 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 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:

_____

Re- certification period _____ to _____

Re-certification Approved by:_____ Date:_____

Caseworker/Program Director Signature

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 ❒ 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 ❒ Children's Health Insurance Program (CHIP) North Dakota Healthy Steps) ❒ Military Health Care (Dept. of Defense, VA) ❒ Direct Purchase (Health Exchange or ACA insurance) ❒ Employment Based (Insurance provided by employer) ❒ 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	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	$	
❒ Alimony / Spousal Support	$		❒ Childcare Voucher	$	
❒ TANF	$		❒ Affordable Care Act Subsidy	$	
❒ Pension / Retirement	$		❒ Other:_____	$	
❒ Worker's Compensation	$		❒ Unknown		
❒ Unemployment	$		❒ I have no income at this time (initial here):_____		
❒ Other:_____	$				

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?	U.S Military	What is your Ethnicity?
❒ 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 ❒ 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 ❒ Children's Health Insurance Program (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 received?	How much?	How often?	What income do you received?	How much?	How often?
❒ Employment	$	$	❒ Alimony / Spousal Support	$	$
❒ Social Security	$	$	❒ TANF	$	$
❒ SSI	$	$	❒ Private Disability Insurance	$	$
❒ SSDI	$	$	❒ Pension / Retirement	$	$
❒ VA Service-Connected	$	$	❒ Worker's Compensation	$	$
❒ VA Non-Service Connected	$	$	❒ Unemployment	$	$
❒ Child Support	$	$	❒ Other:_____	$	$

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?	U.S Military	What is your Ethnicity?
❒ 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 ❒ 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 ❒ Children's Health Insurance Program (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 received?	How much?	How often?	What income do you received?	How much?	How often?
❒ Employment	$	$	❒ Alimony / Spousal Support	$	$
❒ Social Security	$	$	❒ TANF	$	$
❒ SSI	$	$	❒ Private Disability Insurance	$	$
❒ SSDI	$	$	❒ Pension / Retirement	$	$
❒ VA Service-Connected	$	$	❒ Worker's Compensation	$	$
❒ VA Non-Service Connected	$	$	❒ Unemployment	$	$
❒ Child Support	$	$	❒ Other:_____	$	$

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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

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