

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	Addr		Address		
City	State	County	Telephone Number		
Home delivery: Pick		for home delivery, if n	eeded:		
1. Are you Hispanic or Latino?	P  Yes  No				
2. What is your race? (Select	one or more):				
American Indian or Alask	a Native;         Asian;	☐ Black or Africa	n American;		
☐ Native Hawaiian or Other	Pacific Islander; 🔲 \	White			
Household Members Date of Bir (List ALL household members)			Form of ID Presented by the applicant*		
(======================================					
* DL=Drivers License, BC=Birth Ce	ertificate, OT=Other (Spec	ify), NA=Not Available (S	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

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All Household Members	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment/ Unemployment	Other	Subtotals
					1 - Total Manager	
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	e and <u>number of food packs desired</u> :	
If more than one person in the household, list member(s) NOT receive Commodity Supplemental foods:	eligible to	
Re- certification period to		
Re-certification Approved by:  Caseworker/Program Director	 Date: Signature	

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.

### SENDCAA

## CLIENT HOUSEHOLD INTAKE

Intake Date:	/	
-		
_		
Program:		

HEAD OF	HOUSEHOLD INFORM	MATION	
		•	
First Middle	Last	Sc	cial security number
			olar occurry names
Mailing address	City		Zip code
	<b>,</b>		
Physical address (if different from above)	County Ho	ome phone number	Mobile/cell phone
Pura D Addus and	·		·
Email Address:			
Household Type:	•		•
		Two Parent Ho	
Single Person Two	Adults, no children _	Other	
·			
Household Size:			
			·
Birth Date:	Gender: Male	Female	
	- TOTAL TOTAL	romaio	
Phonon NA/Initia Anima Phonon Aliana	o to oth our t	<b>4.</b>	L. 10
Race: White Asian <u>Education</u> Black Multi	:   0 to 8 <sup>th</sup> grade 9 to 12 grade (nor		dical Coverage: Medicare
American Indian	high school grad/0		Medicaid
Other	12+ post secondal		Private Insurance
Ethnicity: Hispanic or Latino	College Degree (2	yr or 4yr)	Indian Health Service
Not Hispanic or Latino			Other
<b>Veteran:</b> yes no <b>Disabled</b> : yes	oo Earman va	20 20	None
<u>Veteran:</u> yes no <u>Disabled</u> : yes	no. <u>Farmer</u> : ye	5 110	
Gross Income Per Month (head of househ	old member):		
Employment \$ TANF	\$	Other	
Unemployment \$ General	Assistance \$	descri	be if other:
Social Security \$ Pension SSI/SSDI \$ Child St			•
φ Oπind Ot	. Ψ	. •	
No Income Househ	old HHS Income Level:	(staff	use only)
Food Stamps: no yes If yes, amount: \$	Fuel	<b>Assistance:</b> yes	no
Housing Status:		•	
Owner Homeless with ro	<del></del>	<del></del>	
Renter Homeless no roo			
Rent/Mortgage <sup>°</sup> Amount: \$	Rental Assistance	<u>e</u> : yes no	
<del>-</del>	• •		•
hereby certify that the information provided in this doc	mont in true and complete 4- 4	no hoot of my limings	dan Lundaratand that

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		encial security	relation to a	nnliaant
Birth date:		race:	ethnicity: hispanic i	not hispanic <u>vetera</u>	an: yes no
disabled: yes no education	on level: medi	cal coverage: medical	d medicare priva	te îns. IHS other	none
monthly income amount:				•	
D D	Gen.Assist. \$ood_stamps: no yes, if y	child support - %	pension \$	Other	
	·	-			
irst name	middle last name		social security	relation to a	pplicant
Birth date:	gender: male female r	ace:	ethnicity: hispanic r	ot hispanic <u>vetera</u>	<u>in:</u> yes no
lisabled: yes no education	on level: medic	cal coverage: medicaio	d medicare privat	e ins. IHS other	none
monthly income amount: \$	employment \$	_unemployment \$	Soc. Sec. \$	SSI/SSDI \$	TANF
o income: F	Gen.Assist. \$ood_stamps: no yes, if ye	_child support \$ es – amount:\$	pension \$	Other	-4
	•				
irst name	middle last name		/ / social security	relation to a	nnlicant
irth date:		ace: e	thnicity: hispanic n	ot hispanic <u>vetera</u>	<u>n:</u> yes no
isabled: yes no <u>educatio</u>	n level: medic	al coverage: medicaid	l medicare privat	e ins. IHS other	none
onthly income amount: \$	employment \$	_unemployment \$	Soc. Sec. \$	SSI/SSDI \$	TANF
\$	Gen.Assist. \$ ood stamps: no yes, if ye	child support \$	pension \$	Other	<del></del>
,					
				relation to a	
irst name <u>irth date:</u>	middle last name gender: male female ra	ace: e	social security thnicity: hispanic ne	relation to aı ot hispanic veteraı	oplicant n: ves no
sabled: yes no educatio				· · · · · ·	
onthly income amount: \$					
\$_	Gen.Assist, \$	.child support \$	pension \$	SSI/SSDI	IANE
o income: Fo	ood stamps: no yes, if ye	s – amount:\$			
·			1 1		
rst name	middle last name			relation to ap	
rth date:	gender: male female ra	.ce: et	thnicity: hispanic no	ot hispanic <u>veterar</u>	<u>ı:</u> yes no
sabled: yes no <u>education</u>	level: medica	al coverage: medicaid	medicare private	ins. IHS other	none
onthly income amount: \$_	employment \$				
income: Fo	Gen.Assist. \$ od stamps: no yes, if yes	child support \$s - amount:\$	pension \$	Other	
		•			
			/ /		
rst name rth date:	middle last name gender: male female ra		social security	relation to ap	plicant
·			hnicity: hispanic no	•	
sabled: yes no <u>education</u>			-		
onthly income amount: \$_ \$	employment \$ Gen.Assist, \$			SSI/SSDI \$	
		COBO SINDOO *	pension \$	_Other	



# **Commodity Supplemental Food Program Affidavit Attesting Age**

(Revised 8/2010)

Name:				
Address:	<u>.</u>			
I,, am (Applicant)	applying for the (	Commodity Sup	plemental	
Food Program with(Name	SENDCAA .e of local agency)			
I understand that I have been am unable to provide such in age, to participate in the Con	formation. I attest	t that I am 60 ye	ars or older and	ove my age, but that I qualify, by
	,	-		
Applicant Signature	<del></del>	Ap	plicant's Date of	Birth
			•	,
•				
Certification Supervisor		Dat	e ·	

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.

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