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

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

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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.