Commodity Supplemental Food Program
Application

Name of Applicant

Telephone Number

County

Physical Address (Street, City, Zip Code)

Mailing Address (If Different) (Street, City, Zip Code)

Client Case Number

Applicant’s Date of Birth

Total No. Living In Household

Names of Qualifying Household Members

Age

Date of Birth

Case Number

Changes must be reported: participants must report changes in household income or composition within 10 days after the change becomes known to the household.

Indicate the source and amount of current (last month’s) income before any deductions, such as taxes and social security. This amount must include income of all household members. “other” income would include commissions; strike benefits, income from trusts, contributions from relatives, etc. If last month’s income is not representative of usual household income, also indicate household’s average income during the previous 12 months.

### Monthly Household Income

<table>
<thead>
<tr>
<th>Gross Salary, Wages</th>
<th>Monthly Amount</th>
<th>Monthly Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Assistance (Welfare)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pensions/Retirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total Household Income

#### 2020 Income Eligibility Guidelines

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Senior Maximum Monthly Household Income</th>
<th>Senior Maximum Annual Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,383</td>
<td>$16,588</td>
</tr>
<tr>
<td>2</td>
<td>$1,868</td>
<td>$22,412</td>
</tr>
<tr>
<td>3</td>
<td>$2,353</td>
<td>$28,236</td>
</tr>
<tr>
<td>4</td>
<td>$2,839</td>
<td>$34,060</td>
</tr>
<tr>
<td>5</td>
<td>$3,324</td>
<td>$39,884</td>
</tr>
<tr>
<td>6</td>
<td>$3,809</td>
<td>$45,708</td>
</tr>
<tr>
<td>For Each Additional Family Member, Add</td>
<td>$486</td>
<td>$5,824</td>
</tr>
</tbody>
</table>
BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- Standards for participation in the program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- You may appeal any decision made by the local agency regarding your denial or termination from the program.
- You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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; I may not receive CSFP benefits at more than one CSFP site at the same time; and improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me to recover the value of the benefits and may lead to disqualification from CSFP. 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 or Guardian

Applicant Signature for Certification from Waiting List

* * * * * * FOR CERTIFYING AGENCY USE ONLY * * * * * *

I have verified the following for each applicant. Check all that apply.

- Identification
- List type of ID
- Age
- Place of Residence
- Household members

Applicant is: ☐ Eligible ☐ Not Eligible

Category: ☐ Elderly ☐ Child

Is caseload available? ☐ Yes ☐ No

Certification Period: First Month: Last Month:

Certifying Official Signature and Date: