

CSFP APPLICATION

Name (Responsible Adult) _____

Address _____

(Number) (Street) (City) (Zip) (County)

Soc. Security Number _____ Phone _____ No. in Household _____

Have you or anyone in the household previously been on:

CSFP? Yes ___ No ___ If yes, when? _____ where? _____

WIC? Yes ___ No ___ If yes, when? _____ where? _____

If terminated from WIC, do you have your Termination letter with you? Yes ___ No ___

Qualifying Household Members:	Age:	Date of Birth:	Category:

RACE: Black White American Indian/Alaskan Native Hispanic Asian/Pacific Islander

HOUSEHOLD INCOME:

Indicate source and amount of current (last month's) income before deductions, such as taxes and Social Security. **THIS AMOUNT MUST INCLUDE ALL INCOME OF ALL HOUSEHOLD MEMBERS.** If last month's income is not representative, please project a yearly income which would be. "Other" income could be commissions, strike benefits, income from trusts, contributions from relatives, etc. Food Stamp benefits do not count as income.

	Amount	How often received
Wages, Salary	_____	_____
Social Security	_____	_____
Public Assist. (Welfare)	_____	_____
Child Support (Alimony)	_____	_____
Pension/Retirement	_____	_____
Self-employment	_____	_____
Unemployment	_____	_____
Other (Specify)	_____	_____

TOTAL HOUSEHOLD INCOME _____

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.

Please see reverse side of this form.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

I understand it is illegal to participate in the CSFP in more than one local agency, or to participate simultaneously in the CSFP and in the WIC Program.

This Certification Form 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 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.

(SIGNATURE OF APPLICANT)

(DATE)

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUALS TO ACT AS MY AUTHORIZED REPRESENTATIVE FOR CSFP:

NAME _____ RELATIONSHIP TO APPLICANT _____

NAME _____ RELATIONSHIP TO APPLICANT _____

NEW CERTIFICATION ELIGIBLE _____ NOT ELIGIBLE _____

CERTIFICATION DATE FROM _____ TO _____

TITLE OF CERTIFIER _____ SIGNATURE _____ DATE _____

2ND CERTIFICATION ELIGIBLE _____ NOT ELIGIBLE _____

CERTIFICATION DATE FROM _____ TO _____

TITLE OF CERTIFIER _____ SIGNATURE _____ DATE _____

CLIENT CONTACT BY PHONE _____ IN PERSON _____

CLIENT WISHES TO REMAIN ON CSFP FOR A CONSECUTIVE SIX MONTHS? _____

CLIENT ADDRESS CHANGED? _____ IF YES, NEW ADDRESS _____

IF INELEGIBLE PLEASE STATE REASON: _____

- _____

- *You may appeal any decision made by the local agency regarding your denial or termination from the program. You have a right to a fair hearing.*
 - *If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.*