DPHHS-FD-034 STATE OF MONTANA

(Revised 01/16) Department of Public Health and Human Services

###### DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### ELDERLY CSFP APPLICATION

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### Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last Name) (First Name) (Middle Initial)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Contact Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ID VERIFIED & TYPE OF ID: Drivers License Birth Certificate SSN** (Don’t record SSN#)

**Alternate ID (Specify)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Program Participation that meets CSFP eligibility criteria? Yes - Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

Number of People in Household Including Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Household Members:** | **Age:** | **Date of Birth:** | **Relationship:** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

### **RACIAL/ETHNIC DATA COLLECTION REQUIREMENT**:

### What is your ethnic category?: Hispanic or Latino Not Hispanic or Latino

### What is your race? (Select one or more): American Indian or Alaskan Native Asian

### Black or African American Native Hawaiian or other Pacific Islander White

**HOUSEHOLD INCOME: (Total Must Not Exceed 130% of the Current Federal Poverty Level Guidelines)**

|  |  |  |
| --- | --- | --- |
| **SOURCE OF INCOME** | **AMOUNT RECEIVED** | **HOW OFTEN RECEIVED** |
| **Wages, Salary** |  |  |
| **Social Security** |  |  |
| **Public Assistance (Welfare)** |  |  |
| **Pension/Retirement (non-SS)** |  |  |
| **Self-Employment** |  |  |
| **Unemployment** |  |  |
| **Other (Specify)** |  |  |
| **Other (Specify)** |  |  |
| **TOTAL HOUSEHOLD INCOME :** |  |

**INCOME COMPLETION DIRECTIONS: Income should be as current as possible (previous month’s)** Indicate source, amount and how often received (weekly, monthly, bi-weekly, quarterly, annually) Income before deductions such as taxes and SS. MUST INCLUDE INCOME OF ALL HOUSEHOLD MEMBERS. If income inconsistently received then project it on an annual basis. “Other, Specify” could be income from commissions, strike benefits, income from trusts, contributions from relatives, etc.

***SNAP BENEFITS (Food Stamps) do not count as income.***

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 aware I may not receive CSFP benefits at more than one CSFP site at the same time. I am also 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.

***Please see reverse side of this form.***

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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) (DATE)

• *You will be notified of your eligibility, eligibility and placement on a waiting list, or ineligibility within 10 days of receipt of this correctly completed and signed application by the local CSFP agency.*

• *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.*

**THE FOLLOWING AUTHORIZED INDIVIDUALS MAY TO ACT AS MY REPRESENTATIVE FOR CSFP**:

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO APPLICANT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO APPLICANT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



###### IF INELEGIBLE PLEASE STATE REASON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**NEW CERTIFICATION: ID VERIFIED:\_\_\_\_\_\_ ELIGIBLE\_\_\_\_\_\_\_\_ NOT ELIGIBLE\_\_\_\_\_\_\_\_**

CERTIFICATION DATE FROM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### 

TITLE OF CERTIFIER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_



**2ND CERTIFICATION : ID VERIFIED:\_\_\_\_\_\_\_ ELIGIBLE\_\_\_\_\_\_\_\_ NOT ELIGIBLE\_\_\_\_\_\_\_\_**

###### CERTIFICATION DATE FROM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TITLE OF CERTIFIER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_



**Every Six Month Review Requirement:** CLIENT CONTACT BY PHONE\_\_\_\_\_\_\_\_ IN PERSON\_\_\_\_\_\_\_\_

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

###### NEW ADDRESS (IF CHANGED)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint\_filing\_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3)email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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