Dear Applicant,

Thank you for your interest in the Commodity Supplemental Food Program (CSFP)! Enclosed you will find the application and other pertinent information.

To process your application, we need the following filled out and mailed to us:

1. **Completed Application.** Fill out the first page of the application. Be sure to list all persons living in your household, regardless of whether they qualify for CSFP or not.
2. **Signed Affidavit Attesting to Age and/or Income.** You do not need to provide proof of age or proof of income. If you would like to include a copy of a driver's license and/or proof of income as a part of your file, you are certainly welcome to. But all that is required is a filled out and signed Affidavit Attesting Age and/or Income.

CSFP is a federally funded program and the information requested is required for all applicants.

I have also enclosed a **Designation for Proxy** form. If you, for any reason, are unable to pick up your commodities, you may designate another person(s) to pick up for you. If you choose to have a proxy or proxies, please make sure they sign the form as well. The only way we will release your commodities to someone other than yourself is if there is a signed proxy form on file.

Once I receive your application, a letter will be mailed to you letting you know whether or not you were approved, denied or placed on a waiting list. We will notify you of any changes if you are on the waiting list. If you have any questions about this application or CSFP, please feel free to call me at 701-232-6219. Thank you!

Best,

Jenae Meske
Program Coordinator

Return application to:
Great Plains Food Bank
Attn: Jenae Meske
1720 3rd Ave. N.
Fargo, ND 58102

Email/Scan:
jmeske@greatplainsfoodbank.org
Fax:
701-232-3871

Supplemental Food Program Application

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
Child Nutrition and Food Distribution Programs
Commodity Supplemental Food Program (CSFP)
Revised (11/15)

Name		**Address**	
City, Zip Code	**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

"USDA is an equal opportunity provider, employer, and lender."

Commodity Supplemental Food Program

Designation for Proxy

(Revised 3/2016)

Applicant Name:	Date:

I, ______________________________ , designate _________________________ to act as a proxy for certification of the Commodity Supplemental Food Program application. If necessary, the proxy is also designated to pick up the food package on my behalf.

This consent shall remain from: ____________________ to ____________________.

______________________________ ______________________________

Applicant Signature **Proxy Signature**

______________________________ ______________________________

GPFB Representative (Print) GPFB Representative (Sign/Initial)

The USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, national origin, sex, disability, 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.htms, 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 Ave, S.W., Washington, D.C.20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard or 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.

Commodity Supplemental Food Program Affidavit Attesting Age and/or Income

(Revised 9/2017)

Applicant Name:	Address:

I, ______________________________ , am applying for the Commodity Supplemental Food
(Applicant)
Program with the Great Plains Food Bank.

☐ 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.**

☐ I attest that I and my household members have the following sources of income:

Name of household member	Source of Income	Monthly amount before deductions

Notes:____

____

____ ____________________
Applicant Signature Applicant's Date of Birth

____ ____________________
Local Agency Representative Date

The USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, national origin, sex, disability, 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.htms, 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 Ave, S.W., Washington, D.C.20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov.

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