Commodity Supplemental Food Program Application

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
Child Nutrition and Food Distribution Programs
Commodity Supplemental Food Program (CSFP)
Revised (9/09)

Name		Address	
City	State	County	Telephone Number
Home delivery: ☐ Pick up: ☐	Directions for home delivery, if needed:		

Participation Category (Please check one):

☐ Elderly (60 + years) ☐ Breastfeeding Woman ☐ Child (0-6 years) ☐ Post-Partum Woman

It is illegal to participate in the CSFP at more than one local agency, or to participate simultaneously in the CSFP and the WIC program. If you participate in both programs simultaneously or make false or misleading statements, misrepresent, conceal or withhold facts regarding your income, you may be disqualified from both programs for a period not to exceed 3 months.

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 Member	Date of Birth	Form of ID Presented by the applicant*

*** DL=Drivers License, BC=Birth Certificate, OT=Other (Specify), SD=Self Declaration (no identification)**

This must be read to or read by the applicant:

This certification form is being completed in connection with my participation in the Commodity Supplemental Food Program. I acknowledge that the Certification Technician or Program Director has thoroughly reviewed this application with me. I acknowledge that all of the information contained on this application is, to the best of my knowledge, true. I am aware that standards for participation are the same for everyone regardless of race, color, or national origin sex, age or disability. I understand that if I am denied the right to participate in the program or terminated from it I may appeal the decision and request a Fair Hearing. I am aware that if approved for participation in the Program nutrition education will be made available to me. 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.

Applicant Signature	**Date**
Caseworker/Program Director Signature	**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, gender, 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.

Income Eligibility Worksheet

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 that would be.

Other income could include commissions strike benefits, income from trusts, contributions from relatives, etc.

Food Stamp, TEFAP or FDPIR benefits do not count as income.

Self- employment income is income derived from rental property, roomers, farming, ranching, or operating your own business. (Provide a copy of last years Federal Income Tax Forms or Current Business Receipts and Expenses,)

Determination of Income (*Monthly Income is determined as follows):*

Weekly Income (x) 4.3
Bi-weekly Income (x) 2.15)
Semi-monthly Income (2 times per month) (x) 2
Monthly income (1 time per month)

Household Member	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment	Unemployment	Other
Total Household Income:						

Total adjusted income from all sources: $________________

Maximum income for a household of _______ is $ ________________

List the name(s) of qualifying household member(s) eligible to receive Commodity Supplemental commodities and number of food packs desired:

____

____

List the name(s) of qualifying household member(s) NOT eligible to receive Commodity Supplemental commodities:

____

____

Certification period: ___________ to ___________

Re- certification period ___________ to ___________ Re-certification Approved

by:______________________________ Date:________________

Certification Supervisor ______________________________

Elderly Income Guidelines for CSFP (130% of poverty) July 1, 2009-June 30, 2010

Persons in Family or Household Size	Monthly
1	$1174
2	$1579
3	$1984
4	$2389
5	$2794
6	$3200
7	$3605
8	$4010

Each additional member add $406