



**Commodity Supplemental Food Program Application**  
 NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION  
 Child Nutrition and Food Distribution Programs  
 Commodity Supplemental Food Program (CSFP)  
 Revised (6/13)

Name		Address	
City	State	County & Zip Code	Telephone Number
Participation Category:			
<input type="checkbox"/> Elderly (60 + years)			

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. What is your race? (Select one or more):		
<input type="checkbox"/> American Indian or Alaska Native; <input type="checkbox"/> Asian; <input type="checkbox"/> Black or African American; <input type="checkbox"/> Native Hawaiian or Other Pacific Islander; <input type="checkbox"/> 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 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, and I may not receive CSFP benefits at more than one CSFP site at the same time. 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 [ ]

<b>Applicant Signature</b>	<b>Date</b>
<b>Caseworker/Program Director Signature</b>	<b>Date</b>

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, national origin, 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.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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 Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of 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.

### 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 all adult participants, and to parents or caretakers of infant and child 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;
- The improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits, and may lead to disqualification from CSFP; and
- 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. **Proof of income is NOT required. If income documentation is available, it must be documented on the application and filed with the client file. If not available, then document income based on verbal confirmation by the applicant on the application.**

### 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 Members	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment	Unemployment	Other
<b>Total Household Income:</b>						

Total adjusted income from all sources: \$ \_\_\_\_\_ or SD if income documentation is not available.

Max. Monthly income for a HH of:

<u>1</u>	is	<u>\$ 1,307.00</u>
<u>2</u>	is	<u>\$ 1,760.00</u>
<u>3</u>	is	<u>\$ 2,213.00</u>
<u>4</u>	is	<u>\$ 2,665.00</u>
<u>5</u>	is	<u>\$ 3,118.00</u>

Certification period: \_\_\_\_\_ to \_\_\_\_\_

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

List the name(s) of household member(s) NOT eligible to Receive Commodity Supplemental foods:

Re- certification period \_\_\_\_\_ to \_\_\_\_\_

Re-certification Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Certification Supervisor

Agency Name: Red River Valley  
Community Action  
Address: 1013 N 5<sup>th</sup> Street  
Address: Grand Forks, ND 58203  
Phone: (701) 746-5431  
Fax: (701) 746-0406

Commodity Supplemental Food Program  
Affidavit Attesting Age  
(Revised 7/2014)

Applicant Name:	Address:
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I, \_\_\_\_\_, am applying for the Commodity Supplemental  
(Applicant)

Food Program with RRVCA  
(Name of local agency)

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.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Applicant's Date of Birth

\_\_\_\_\_  
Local Agency Representative

\_\_\_\_\_  
Date

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, national origin, 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.)

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