

APPLICATION FOR COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

CSFP Partner Agency: _____

(ONE APPLICATION PER QUALIFYING PERSON)

APPLICANT: My, or my child's, eligibility for CSFP is based upon the following statements. I understand we need a separate application for each applicant.

1. Applicant Category (check only one box):

- SENIOR age 60 or older
- PREGNANT
- POSTPARTUM mother
- CHILD between 1 & 6 years old
- INFANT under 1 year old

2. I/the applicant confirm the following:

- a. I am not currently on WIC YES NO
- b. I meet the Federal income eligibility guidelines provided by this agency YES NO

Please print all information

Name of Applicant: _____ Birth Date: ____/____/____
(Last) (First) (Middle)

Name of Parent/Guardian (if applicable): _____

Mailing Address: _____, AK Zip _____
Street or PO Box Apt # City

Physical Address (if different): _____, AK Zip _____
Street Apt # City

Home Phone _____ Message Phone: _____

Are you Hispanic or Latino? (Please choose only one): YES NO

What is your race? (Please choose one or more) Alaska Native/American Indian; Asian;
 Black/African American; Native Hawaiian/Pacific Islander; White.

Racial and/or ethnic data collected on this form has **NO EFFECT ON THE ELIGIBILITY DETERMINATION OF THE HOUSEHOLD.**

Primary language: _____ How many people in your household? _____

Total household income before deductions: \$_____ per month, year.

Did the applicant receive an AK Permanent Fund Dividend this year? yes no If yes, did you include this amount in your total household income? yes no

Is the applicant on any of these programs? Medicaid: yes no Food Stamps: yes no ATAP: yes no

WIC: yes no – I understand it is illegal for the recipient to be on CSFP and WIC at the same time.

Office Use Only: Eligible Ineligible Date of Certification: _____

Category: IN CH PG PP SR

For PP/PG applicants please list expected or actual date of baby's birth: _____ Date eligibility will end for child: _____

Signature of certifying official: _____ Date: _____

Printed name of certifying official: _____ Phone: _____

Before signing, know your rights and responsibilities under the Commodities Supplemental Food Program (CSFP). By checking the "yes" box next to the statements listed below, I am saying that I understand:

- Standards for CSFP are the same for everyone regardless of race, color, national origin, sex, age, disability, or political belief. yes no
- To file a complaint of discrimination, write: USDA, Director; Office of Civil Rights; Room 326-W, Whitten Building; 1400 Independence Avenue, S.W.; Washington D.C. 20228; (202)750-9410 or call (202) 720-5964 (Voice and TDD). USDA is an equal opportunity provider and employer. yes no
- My rights and obligations under CSFP: the information I have provided is correct. CSFP partner agencies and program officials may verify any of this information. yes no
- If I have intentionally lied or withheld the truth, I may be prosecuted under the law and will have to pay back what I have received. yes no
- I may appeal any decision made by CSFP partner agencies regarding my eligibility for CSFP. yes no
- I have received information outlining my rights to request a Fair Hearing if my application is unjustly denied. I understand that I must request a hearing within 60 days of the written date of denial. yes no
- The recipient CANNOT be enrolled in WIC and CSFP at the same time. yes no
- I CANNOT sell or trade foods or use someone else's foods for my household. yes no
- I agree to inform the CSFP partner agency within the first 15 days if my contact information (i.e., my home address or phone number), my income, or my household composition changes. yes no
- If I do not pick up my commodity foods for three months in a row, I may be considered an "inactive" CSFP participant and removed from the program. If I choose to remain a participant in CSFP, I must notify the CSFP partner agency or participate within 90 days of my original application date. yes no
- CSFP recipients who are removed from the program for being "inactive participants" are allowed to re-apply for benefits by filling out another CSFP application. If a waiting list exists, however, I understand my application will go on the list according to the date it was received. yes no
- I must fill out a new application annually and recertify each October. yes no

If you disagree with the denial or termination of assistance, you can request a Fair Hearing within sixty (60) days of the decision, by contacting State of Alaska Family Nutrition Programs at 130 Seward Street, Room 508, Juneau, Alaska 99801; or call 907 465-3100. A request for a Fair Hearing shall be personally presented, either orally or in writing. A request for an informal review must include: 1) name, address and contact phone number, 2) the reason for the grievance, 3) the action or relief sought; and 4) signature of applicant or representative.

A Hearing Officer will arrange a date, time and place convenient to both you and Family Nutrition Programs. In preparing for the hearing you have the right to examine any documents, including records and regulations that are directly relevant to the hearing. You have the right to be represented by counsel or any other person chosen as your representative. You have the right to a private hearing unless you request a public hearing. You have the right to present evidence and arguments in support of your grievance and to controvert evidence. You also have the right to cross-examine all witnesses. The Hearing must render a decision within (14) days of the hearing. The decision of the Hearing Officer will be final.

APPLICANT or GUARDIAN _____ Date _____
Signature

Printed Name of Applicant or Parent/Guardian: _____

My approved alternate(s) (full name): _____
If you would like to give permission for someone to pick up food on your behalf, please name them here.