COMMUNITY ACTION AGENCY
COMMODITY SUPPLEMENTAL FOOD PROGRAM
APPLICATION FOR PARTICIPATION

NAME		ADDRESS	
CITY	STATE	COUNTY	TELEPHONE
DIRECTIONS FOR REACHING HOME			

You may not participate in the WIC and Commodity Supplemental Food Program at the same time. You may not participate in the Commodity Supplemental Food Program at more than one site. If you participate in both programs at the same time or if you 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.

ELIGIBLE HOUSEHOLD MEMBERS:

(We are authorized under the Tax Return Act of 1976 to ask for your Social Security Number. We are authorized under Title VI of the Civil Rights Act of 1964 to ask for Racial Ethnic Heritage information. YOU DO NOT HAVE TO PROVIDE IT. Failure to provide this information will not affect consideration of your application.)

Name	Date of Birth	Social Security Number	Categorical Eligibility					
			Breastfeeding Women	*Infant*	*Child*	*Postpartum Women*	*Elderly*	*Homebound Elderly*
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

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 sex, age or disability.

TO FILE A COMPLAINT OF DISCRIMINATION WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W WHITTEN BUILDING, 14TH AND INDEPENDENCE AVENUE SOUTH WEST, WASHINGTON , DC 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD).

USDA IS AN EQUAL OPPORTUNITY PROVIDER AND EMPLOYER

Exhibit VI

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, 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)

Apply factor to income from each category before entering income in chart below.

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

Total adjusted income from all sources = $_____

Maximum Income for a household of _____ is $ _____

_____ is ☐ Eligible ☐ Ineligible to receive Commodity Supplemental Foods
Name of qualifying household member

Certification_____ to _____

Re- certification period _____ to _____ Re-certification Approved by:_____ Date:_____
Certification Supervisor