COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
COMMODITY SUPPLIMENTAL FOOD PROGRAM (CSFP)
SFN 62427 (01-2024)

Applicant's First Name	Last Name	
Address	City	ZIP Code
County	Telephone Number	
Date of Birth (mm/dd/yyyy)	Preferred Method Home Delivery Pick Up	

Ethnicity

Hispanic/Latino

Not Hispanic/Not Latino

Race

American Indian or Alaska Native

Black or African American

Native Hawaiian or Other Pacific Islander

Asian

White

Household Members (other than self)	Date of Birth (mm/dd/yyyy)	CSFP Eligible (Yes/No)

Household Gross Monthly Income Information:

Earned Wages	SS	SSI	Public Assistance	Self-Employment
Pension	VA	Other	**Total Household Size**	**Total Monthly Income**

Age Verification/Attestation:

Required Identification Verified (copy of identification with case file if available):

Drivers's License

Birth Certificate

State ID

Tribal ID

Attest applicant's age is 60 or over

Proxy Identification:

The following individuals are authorized to act as my representative or take receipt of my food pack for CSFP:		
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Applicant's Rights 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.

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 12 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

Signature of Applicant	Date (mm/dd/yyyy)
Signature of Certifier	Date (mm/dd/yyyy)

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or 2) fax: (833) 256-1665 or (202) 690-7442; or 3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

GENERAL INTAKE FORM

Red River Valley Community Action, 4212 Gateway Dr, Grand Forks ND 58203
Phone: 701-746-5431; Fax: 701-746-0406

Office Use Only

Project Start Date ____/____/____ Staff ____

Name of Head of Household ____

Family Type: ____ Single Person _____ Family _____ Other

Client Record

Name ______________________ ___________________ ____________________________ __________
First Middle Last Suffix

Social Security Number _______ - _____ - ________

U.S. Veteran _____ No _____ Yes

Mailing Address Street _____________________________ City _______________________________

State _____ Zip Code _________________

Primary Phone _______________________ Secondary Phone ____________________

Email Address ____

CLIENT DEMOGRAPHICS

Date of Birth _______/________/_______
Month Day Year

Gender (s) _____ Woman (girl, if child) _____ Man (boy, if child) _____Transgender

_____ Non-Binary _____ Questioning _____ Culturally Specific Identity (e.g. Two-Spirit)

_____ Different Identity (specify): ____

_____ Client prefers not to answer

Race (s) ______ American Indian, Alaska Native, or Indigenous ______ Asian or Asian American

______ Black, African American, or African ______ Hispanic/Latino/e/o

______ Middle Eastern or North African ______ Native Hawaiian or Pacific Islander

______ White ______ Client prefers not to answer

Additional Race & Ethnicity: ____
(optional) specify

Relationship to Head of Household

______ Self ______ Head of household's spouse or partner ______ Head of household's child

______ Other relation to head of household ______ Non-relation to head of household

DISABILITIES

Disabling Condition ______ No ______ Yes ______ Client prefers not to answer

Disability Type DK = Client Doesn't Know PNTA = Client prefers not to answer	**Disability Determination**	**If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently**
Alcohol Use Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Both Alcohol and Drug Use Disorders	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Chronic Health Condition	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Developmental Disability	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Drug Use Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
HIV/AIDS	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Mental Health Disorder	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA
Physical Disability	___ Yes ___ No ___DK ___PNTA	___ Yes ___ No ___DK ___PNTA

HEALTH INSURANCE

Covered by Health Insurance ___ No ___ Yes ___PNTA

Medicaid ___ No ___Yes

Medicare ___ No ___ Yes

State Children's Health Insurance Program ___ No ___ Yes

Veteran's Health Administration ___ No ___ Yes

Employer Provided Insurance ___ No ___ Yes

Health Insurance through COBRA ___ No ___ Yes

Private Pay Insurance ___ No ___ Yes

State Health Insurance for Adults ___ No ___ Yes

Indian Health Services Program ___ No ___ Yes

Other (specify) ___________________ ___ No ___ Yes

MONTHLY INCOME

Income from any source ___ No ___ Yes ___ DK ___ PNTA

Alimony or other spousal support ___ No ___ Yes $_____________

Child Support ___ No ___ Yes $_____________

Earned income (employment) ___ No ___ Yes $_____________

General Assistance (GA) ___ No ___ Yes $_____________

Other (specify) _________________ ___ No ___ Yes $_____________

Pension or retirement income
from a former job ___ No ___ Yes $_____________

Private disability insurance ___ No ___ Yes $_____________

Retirement income from
Social Security ___ No ___ Yes $_____________

Social Security Disability ___ No ___ Yes $_____________
Insurance (SSDI)

Supplemental Security ___ No ___ Yes $_____________
Income (SSI)

Monthly Income (continued)

Temporary Assistance for Needy Families (TANF) ___ No ___ Yes $____________

Unemployment Insurance ___ No ___ Yes $____________

VA Non-Service-Connected Disability Pension ___ No ___ Yes $____________

VA Service-Connected Disability Pension ___ No ___ Yes $____________

Worker's Compensation ___ No ___ Yes $____________

Total Monthly Income $_______________

NON-CASH BENEFITS

Non-cash benefits from any source ___ No ___ Yes ___ Client prefers not to answer

Supplemental Nutrition Assistance (SNAP) (previously known as food stamps) ___ No ___ Yes

Special Supplemental Nutrition Program for Women, Infants & Children (WIC) ___ No ___ Yes

TANF child care services ___ No ___ Yes

TANF transportation services ___ No ___ Yes

Other TANF-funded services ___ No ___ Yes

Other (specify) _______________________ ___ No ___ Yes

Employed ___ No ___ Yes

If Yes, type of employment ____ Full-time ____ Part-Time ____ Seasonal/Sporadic (including day labor)

If No, why not employed ____ Looking for work ____Unable to work ____ Not looking for work

DOMESTIC VIOLENCE

Survivor of domestic violence? ____ No ____ Yes ____ Client prefers not to answer

If yes, when experience occurred ____ Within the past 3 months ____ 3 to 6 months ago

____ 6 to 12 months ago ____ More than a year ago ____ DK ____PNTA

If yes, currently fleeing? ____ No ____ Yes ____ DK ____ PNTA

I ______________________________ ______-_____-______ ____________________
(Name) (Social Security Number) (Date of Birth)

give permission to the agency staff and other agencies that are initialed below, to exchange written and verbal information concerning myself and/or dependents. My name as well as other identifying information may be used for referrals and in discussion of my needs with other service agencies and in data collection software.

Initial	Agencies
_____	Grand Forks County Social Services
_____	The Salvation Army
_____	Grand Forks Housing Authority
_____	Prairie Harvest
_____	North Dakota Job Service
_____	Local Law Enforcement & Probation
_____	Northeast Human Service
_____	Grand Forks Public Health
_____	Legal Services of North Dakota
_____	Area Churches: ______________________________
_____	Community Violence Intervention Center
_____	St. Joseph's Social Care
_____	Grand Forks Public Schools
_____	Social Security (SSI & SSDI)
_____	Valley Health
_____	Women, Infant, Children (WIC)
_____	Division of Community Services/Department of Commerce (DCS/DOC)
_____	Other – Please specify: __________________________
_____	Other – Please specify: __________________________
_____	Other – Please specify: __________________________

I understand that this information will be shared only with agencies, software and individuals who need this information to assist me in obtaining services. I understand that my contact information will be used to receive agency updates.

I understand that I have the right to not supply the information requested, however, without this information, the agency may not be able to provide me with the services that I am requesting.

I understand that I may cancel this document at any time by providing any Red River Valley Community Action staff with a written statement asking that these privileges be terminated. This consent will automatically expire at the time of case closure.

Please add me to the RRVCA email list so I can stay informed about new programs, services and special events.

Email Address: ________________________________

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Staff Date

A PHOTOCOPY OF THIS CONSENT WILL BE CONSIDERED AS VALID AS THE ORIGINAL