

Commodity Supplement Food Program Application

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
 Child Nutrition and Food Distribution Programs
 Commodity Supplemental Food Program (CFSP)
 Revised (10/2019)

Return to:

RRVCA
 4212 Gateway Dr.
 Grand Forks, ND 58203

Name:	
Address:	
City, State, Zip:	County:
Telephone:	

What is your race? (Select one or more): AI=American Indian or Alaska Native; AS=Asian; BL=Black or African American; NH=Native Hawaiian or Other Pacific Islander; WH=White

Household Members (List ALL household members)	Date of Birth	Form of ID Presented by the applicant*	RACE	Hispanic or Latino Yes or No

*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 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 []

Applicant Signature	Date
Caseworker/Program Director Signature	Date

Applicant's Rights and Responsibilities

The local agency will provide notification of a decision to deny or terminate CFSP 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 to 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 CFSP 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, employee's social security taxes, insurance premiums, and bonds.

Document all household income below. If available, provide income documentation to the case worker along with the application. Proof of income is not required.

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

For Office Use Only:

Maximum income for a household of _____ is \$ _____. Certification period: _____ to _____

If more than one person in the household, list member(s) eligible and number of food packs desired:

_____ Food Packs: _____

If more than one person in the household, list member(s) NOT eligible to receive Commodity Supplemental foods:

"This institution is an equal opportunity provider

Commodity Supplemental Food Program
Affidavit Attesting Age
(Revised 11/2015)

Applicant Name:	Address:
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I, _____, am applying for the Commodity
(applicant)
Supplemental Food Program with Red River Valley Community Action.

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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;
- (2) FAX: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

Commodity Supplemental Food Program
Designation for Proxy
(Revised 11/2015)

Applicant Name:	Date:
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I, _____, designate _____ to act as a proxy for certification of the Commodity Supplemental Food Program application. If necessary, the proxy is also designated to pick up the food package on my behalf.

This consent shall remain from: _____ to _____.

Applicant Signature

Proxy Signature

Local Agency Representative (Print)

Local Agency Approval (Sign/Initial)

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