



Second Harvest Food Bank of East Central Indiana
Commodity Supplemental Food Program (CSFP) Certification Form

Local Agency EC _____

Distribution Site _____

APPLICANT INFORMATION					PLEASE PRINT
Date ____/____/____					
Name of Applicant _____					
LAST		FIRST		MIDDLE	
Address _____					
STREET ADDRESS OR BOX NUMBER			CITY	COUNTY	STATE
Telephone No. (____) _____ Date of Birth _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female					
Household Income \$ _____ Monthly How many persons are supported by this income? _____					
Permanent Proxy _____ Daytime phone (____) _____					
LAST		FIRST		MIDDLE	

<p>Ethnic Data: (please check one) Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Racial Data: (please check one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native and White <input type="checkbox"/> Asian and White <input type="checkbox"/> Black or African American and White <input type="checkbox"/> American Indian or Alaska Native and Black or African American</p>	<p>Do you receive Food Stamps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you want help in applying for Food Stamps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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• Are you 60 years old or older? Yes No

• Do you live Wabash County, Indiana? Yes No

• Does your income fall into these guidelines listed below? Yes No

PERSONS IN HOUSEHOLD	MONTHLY MAXIMUM	PERSONS IN HOUSEHOLD	MONTHLY MAXIMUM
<u>1</u>	<u>\$1180.00</u>	<u>6</u>	<u>\$3,249.00</u>
<u>2</u>	<u>\$1,594.00</u>	<u>7</u>	<u>\$3,663.00</u>
<u>3</u>	<u>\$2008.00</u>	<u>8</u>	<u>\$4,077.00</u>
<u>4</u>	<u>\$2,422.00</u>	<u>EXTRA MEMBER</u>	<u>\$414.00</u>
<u>5</u>	<u>\$2,836.00</u>		

I hereby certify that this assessment was made on the basis of information supplied by the applicant concerning eligibility.

Interviewer's Signature _____ ID # _____

NOTES:

TO BE COMPLETED BY PROGRAM STAFF
Date of application (this certification) _____
Date certified/denied _____
Date food issued (this certification) _____
Date eligibility data taken _____



PARTICIPANT AGREEMENT

- 1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. Program benefits are provided in connection with the receipt of Federal assistance.
3. Program officials may verify information on this form.
4. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
5. The local agency will make health service and nutrition education materials available to me and I am encouraged to participate in these services.
6. I understand that participating in the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP) at the same time or participating in more than one WIC or CSFP program at the same time is not allowed and will result in being removed from at least one program.
7. I have been advised on my rights and obligations under the CSFP.
8. If participating in CSFP, I will pick up food as directed. Failure to pick up food as directed may result in being dropped from the program.
9. I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.
10. I understand CSFP is a supplemental food program.
11. I consent to the release of information by program staff to the Indiana State Department of Health, another CSFP agency to which I may transfer, and to officials of USDA.

REQUESTING A FAIR HEARING

If I am dissatisfied with any decisions made regarding the eligibility or receipt of benefits, the following procedure may be followed:

- 12. I may talk with the CSFP workers at this distribution site or contact Second Harvest Food Bank of East Central Indiana's CSFP project Coordinator to have my case reviewed. If I am not satisfied with the explanation of the workers or the Second Harvest Food Bank of East Central Indiana's project coordinator, I may request a fair hearing by mail, or present a written request in person to Second Harvest Food Bank of East Central Indiana's project coordinator. My request should be made within 60 calendar days from the date the local agency mailed or gave me notice of denial or termination of benefits to the State CSFP Specialist who will contact me or have his/her designated representative within 7 business days after my request is received. At this time, a date will be set for the hearing. I will be notified at least 10 calendar days before the hearing. The hearing will be held within 21 calendar days of receipt of the request for a fair hearing. I may present my position personally or select a representative. If my representative or I cannot appear at the scheduled time and place, I may request the hearing officer to change it. I will be provided one opportunity to reschedule the hearing date upon written request submitted to the CSFP Office at the Indiana State Department of Health, CSFP Program. If my representative or I do not appear for the hearing or if I request the hearing to be canceled, it will be canceled. The CSFP project coordinator and I will be sent a written decision concerning the hearing within 45 calendar days after the hearing was requested. The Second Harvest Food Bank of East Central Indiana CSFP project coordinator must follow the decision. If I do not agree with the decision made at the local hearing, I may ask for an appeal by contacting the state agency as follows: CSFP-Office of General Counsel, Indiana State Department of Health/CSFP, 2 N Meridian Street 8E, Indianapolis, IN 46204. If I desire an appeal, a request for a rehearing must be filed within 10 calendar days after the receipt of the fair hearing decision. The detailed Fair Hearing Procedures are on file with the local agency CSFP program director. A copy is available upon request.

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 []

APPLICANT
SIGNATURE

SELF OR RELATIONSHIP TO APPLICANT

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 Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired 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.