

(AGDAAGUX TRIBAL COUNCIL

Food Distribution Program

P O BOX 249

King Cove Alaska

PHONE: (907) 497-2648

FAX: (907) 497-2803

HEAD OF HOUSEHOLD SOCIAL SECURITY
NUMBER: _____

HAVE YOU APPLIED FOR FOOD STAMPS
DO YOU RECEIVE FOOD STAMPS NOW

YES OR NO
YES OR NO

HOW MANY PEOPLE IN YOUR HOUSEHOLD _____

APPLICATION FOR FOOD DISTRIBUTION

ANSWER THE FOLLOWING QUESTIONS HONESTLY AND COMPLETELY. IF YOU KNOW BUT REFUSE TO ANSWER OR GIVE NEEDED INFORMATION, YOUR HOUSEHOLD (MEMBERS WHO PREPARE AND PURCHASE MEALS TOGETHER) WILL NOT BE ELIGIBLE FOR FOOD DISTRIBUTION BENEFITS.

APPLICATIONS CAN BE FILED BY THE APPLICANT OR AN AUTHORIZED REPRESENTATIVE AT THE TRIBAL OFFICE, BY MAIL, OR BY FAX MACHINE.

IMPORTANT: WHEN YOUR HOUSEHOLD IS INTERVIEWED, PLEASE BRING PROOF OF ALL HOUSEHOLD INCOME. FOR EXAMPLE: PAY STUBS, A COPY OF ALL PAYSTUBS OR COPIES OF AWARD LETTERS FROM SOCIAL SECURITY BENEFITS, SUPPLEMENTAL SECURITY INCOME, GA, PA, AND TANF. COMPLETED APPLICATIONS WILL SPEED UP THE REVIEW OF YOUR APPLICATION.

HEAD OF HOUSEHOLD: _____

MAILING ADDRESS: _____
STREET CITY STATE: AK ZIP

_____ AK
PO BOX # CITY STATE ZIP

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

HOUSEHOLD LOCATION: _____

HOUSEHOLD RACIAL-ETHNIC HERITAGE:

ALTHOUGH, YOU ARE NOT REQUIRED TO PROVIDE THIS INFORMATION, YOUR COOPERATION WILL HELP DETERMINE COMPLIANCE WITH THE FEDERAL CIVIL RIGHTS LAW. IN NO INSTANCE WILL THIS INFORMATION BE USED IN CONSIDERING YOUR ELIGIBILITY FOR ASSISTANCE. IF YOU DECLINE TO PROVIDE THIS INFORMATION IT WILL IN NO WAY AFFECT CONSIDERATION OF YOUR APPLICATION. WE ARE AUTHORIZED TO ASK FOR THIS INFORMATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

BLACK/AFRICAN AMERICAN: _____
HISPANIC or LATINO: _____
ASIAN OR PACIFIC ISLANDER: _____
AMERICAN INDIAN OR ALASKAN NATIVE: _____
WHITE - NOT OF HISPANIC ORIGIN: _____

FOR OFFICE USE ONLY:
CASE NUMBER: _____
DATE RECEIVED: _____

ARE YOU OR ANYONE IN YOUR HOUSEHOLD ENROLLED WITH THE BUREAU OF INDIAN AFFAIRS (BIA) OR AN ALASKA NATIVE REGIONAL CORPORATION OF THE ALASKA NATIVE CLAIMS SETTLEMENT ACT (ANCSA)?

BIA or ANCSA ENROLLMENT NUMBER: _____

ANCSA CORPORATION NAME: _____

(YES OR NO)

DO YOU RESIDE WITHIN THE VILLAGE BOUNDARY? _____

(YES OR NO)

COPY UTILITY/PHONE BILL: _____

(YES OR NO)

FILL IN ALL BLANKS FOR EACH HOUSEHOLD MEMBER, INCLUDING YOURSELF. PEOPLE WHO LIVE AND EAT WITH YOU SHOULD BE LISTED AS HOUSEHOLD MEMBERS. (Do not list roomers and boarders)

ALTHOUGH YOU ARE NOT REQUIRED TO DO SO, WE WOULD LIKE YOU TO INCLUDE THE SOCIAL SECURITY NUMBER OF EACH MEMBER OF YOUR HOUSE-HOLD WHO HAS ONE. THIS WILL HELP US TO IDENTIFY YOUR HOUSEHOLD CORRECTLY. THESE SOCIAL SECURITY NUMBERS MAY ALSO BE USED IN PROGRAM REVIEWS OR AUDITS TO MAKE SURE YOUR HOUSEHOLD IS ELIGIBLE FOR FOOD DISTRIBUTION BENEFITS. WE ARE AUTHORIZED TO ASK FOR THIS INFORMATION UNDER THE TAX REFORM ACT OF 1976.

	<u>NAME (First, Middle, Last)</u>	<u>DATE OF BIRTH</u>	<u>SOCIAL SECURITY #</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	SELF
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____

{AGDAAGUX TRIBAL COUNCIL} OFFICIAL USE ONLY

HOUSEHOLD LOCATED ON OR NEAR VILLAGE BOUNDARY? _____ YES OR NO

HOW WAS LOCATION VERIFIED? _____

FOR ANTHC FDPIR OFFICE USE ONLY

EIS CHECKED FOR THIS APPLICANT'S SNAP/FOOD STAMP STATUS? _____ YES OR NO

WHO CHECKED (INITIAL): _____ DATE: _____

SOA Case #'s: _____ Case # 2: _____

RULES OF UNDERSTANDING: By my initials below I understand and agree to the following eight (8) rules:

- 1) To report any changes in residence within 10 days.
- 2) To report any changes to my household size within 10 days.
- 3) To report any changes in my shelter/utility expenses within 10 days.
- 4) To report any changes or increase in gross monthly income over \$100 within 10 days.
- 5) To report any changes in a household member's obligation to pay child support within 10 days.
- 6) It is prohibited to receive both SNAP (food stamps) or FDPIR benefits within the same month.
- 7) It is prohibited to give any false or misleading information to receive food distribution benefits.
- 8) It is prohibited to barter/trade or sell my household's food distribution benefits.

Initials: _____

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: If you or a household member knowingly/willingly violate the rules initialized above, it is considered an Intentional Program Violation (IPV). Households who have been found guilty of committing an IPV will be ineligible to participate in both FDPIR and SNAP programs for a period of twelve (12) months for the first violation, 24-months for the second violation and permanently for the third violation; even prosecuted by authorities.

Initials: _____

FAIR HEARING: If you disagree with any action taken on your case, you and/or your representative have the right to request a fair hearing. You may request a fair hearing verbally or in writing. If you request a fair hearing, your case may be presented by a member of your household or representative, such as a legal counsel, a relative, a friend or other spokesperson.

Initials: _____

NON-DISCRIMINATION STATEMENT

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, religious creed, disability, age, political beliefs, 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, audiotape, 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, D.C. 20250-9410;
- 2) Fax: (202) 690-7442; or
- 3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Initials: _____

AUTHORIZATION: I authorize the release of any necessary information or forms to ANTHC's Food Distribution Office and {AGDAAGUX TRIBAL COUNCIL}, from individuals, businesses, schools, banking institutions, Federal/State/Tribal agencies needed to verify my eligibility for the Food Distribution Program. I understand that this information will be kept confidential and used only for the purpose of helping to document my eligibility for the Food Distribution Program. This authorization is good for the entire period for which I am deemed certified and eligible to receive food distribution benefits, which could last up to 24 months or until revoked by me in writing.

OPTIONAL (Parents w/Children): By my initials below I authorize the ANTHC Food Distribution Office the permission to share my household information with the State of Alaska, Division of Child & Early Development, Child Nutrition Programs, for the sole purpose of automatically enrolling my child(ren) to participate in and receive free school meals for as long as I am certified for food distribution benefits.

INITIAL YES:	INITIAL NO:
--------------	-------------

CERTIFICATION STATEMENT: I certify that I have read this application and that the information contained in it is true and correct to the best of my knowledge. I understand that I must comply with program rules and provide additional documentation if required, and that any false or misleading information on this form may be grounds for disqualification and/or claim action. By my initials above I have acknowledged complete understanding of my rights and responsibilities to participate and receive food distribution benefits, and that I am responsible for reporting any changes in my household's size, changes income over \$100 and/or changes to my contact information to the Food Distribution Program Tribal Agency Office, within 10 days of the date the changes become effective.

Applicant or Authorized Representative Signature

Date

Tribal Agency Representative Signature

Date

AUTHORIZED REPRESENTATIVE(S): Person(s) identified outside my household are authorized to pick up my food package

#1 - Name: _____

#1 - Address: _____

#1 - Phone(s): _____

#2 - Name: _____

#2 - Address: _____

#2 - Phone(s): _____

#3 - Name: _____

#3 - Address: _____

#3 - Phone(s): _____