

### Application for Benefits

TEFAP CSFP

**For DS Use Only:**

Date:  
Client ID#:  
DS:

#### Applicant Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Number of People in the Household: \_\_\_\_\_

Gender (Optional): Male Female Undisclosed

Marital Status (Optional): Single Married Divorced Separated Widowed Undisclosed  
Common-Law

Address (No., Street): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Housing Type (Optional): Emergency Shelter/Mission/Transitional Evacuee Unhoused  
Own Home Private Rental Public (Social) housing  
With Family/Friends Youth Home/Shelter Undisclosed Other  
No Fixed Address/Undisclosed

Language (Optional): \_\_\_\_\_

Ethnicity (Required for CSFP): White/Anglo Black/African American Hispanic/Latino  
Pacific Islander Asian American Indian/Native American  
Alaska Native/Aleut/Eskimo Middle Eastern/North African Other

Self-identified as (Optional): Disability Undisclosed Veteran Mental Illness N/A  
Pregnant Postpartum Breastfeeding Other

#### Authorization for Proxy

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

Proxy's Printed Name(s): \_\_\_\_\_

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. CSFP Clients: 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

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

Applicant's Name (Please Print): \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Household Member Information 1**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship:      Spouse      Child      Parent      Sibling      Grandparent      Other Relative  
                          Boyfriend/Girlfriend      Friend      Undisclosed

Gender (Optional):      Male      Female      Undisclosed

**Household Member Information 2**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship:      Spouse      Child      Parent      Sibling      Grandparent      Other Relative  
                          Boyfriend/Girlfriend      Friend      Undisclosed

Gender (Optional):      Male      Female      Undisclosed

**Household Member Information 3**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship:      Spouse      Child      Parent      Sibling      Grandparent      Other Relative  
                          Boyfriend/Girlfriend      Friend      Undisclosed

Gender (Optional):      Male      Female      Undisclosed

**Please send this completed application to**

Email: [coordinatedhungerreliefprogram@azdes.gov](mailto:coordinatedhungerreliefprogram@azdes.gov)

Mail: Arizona Department of Economic Security  
 Child and Community Services Division  
 Coordinated Hunger Relief Program (Mail Drop 4382)  
 1789 W. Jefferson Street  
 Phoenix, AZ 85007

**For more information about DES food assistance programs, please visit:**

[des.az.gov/services/basic-needs/food-assistance](http://des.az.gov/services/basic-needs/food-assistance)

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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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local