

United Tribes of KS & SE NE, Inc. FOOD DISTRIBUTION PROGRAM APPLICATION
3301 THRASHER ROAD
WHITE CLOUD, KS 66094-4028
Phone: 785-595-3291 Fax: 785-595-6667 Website: unitedtribes.net

INSTRUCTIONS: Complete the following information. If you refuse to **cooperate/provide verification**, your application will be denied. You must provide proof/verification of all income and allowable deductions.

Name (Head of Household) _____

Telephone (include area code) _____ Household Size _____

Home Address _____ PO Box _____

City, State, Zip _____ County _____

RESIDENCE ON RESERVATION ☐ YES ☐ NO If no, your household must contain one person who is a member of a Federally recognized tribe. TRIBE AFFILIATION _____

HOUSEHOLD MEMBER: Complete for EACH member of the household. You household means yourself and the people who live with you. (Attach a separate sheet if needed.)

Last, First Please print	Relationship self, spouse, child	Social Security #	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INCOME (EARNED AND UNEARNED): List **all** income for **each** member of the household. This includes: wages, social security, unemployment, child support, alimony, pensions etc. **Verification of full month income is required for all household members.**

Name	Source of income	Type wages, s.s., child support, ect	Gross	How often
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SELF EMPLOYMENT: If you are self employed complete the following section. Please provide a copy of last years federal income tax form. (1040, Schedules F, C, E)

Name	Occupation	Gross
_____	_____	_____
_____	_____	_____

UTILITY DEDUCTION: Households that incur at least one monthly shelter or utility expense are allowed deduction of \$744. **Verification is required.**

Name rent/utility co.	Name on bill	Amount
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ALLOWABLE DEDUCTIONS: Verification is required.

Dependent Care: Provider _____
Amount Paid _____ How often _____
Child Support: Amount ordered _____ Amount paid _____
Medicare: Part B insurance Name _____ Amount paid _____
Elderly/Disabled: Medical expenses over \$35 per month.
Name _____ Amount _____

AUTHORIZED REPRESENTATIVE: Someone outside the household to pick up for you.

Name	Address	Telephone
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What is your ethnic category? ☐ Hispanic or Latino ☐ Not Hispanic or Latino
What is your race? ☐ American Indian or Alaskan Native ☐ White ☐ African American
☐ Hispanic Origin ☐ Asian or Pacific Islander

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

PENALTY WARNING: If your household receives commodity food it must follow the rules below. Failure to comply with these rules may result in a monetary claim being filed against the household and/or disqualification from participation in the Food Distribution Program.

1. Do not make false or misleading statements, misrepresent, conceal or withhold facts regarding income, household size, and/or Food Stamp Program in order to obtain Food Distribution Program benefits which your household is not entitled to receive.
2. Do not trade or sell commodity food.
3. Do not participate simultaneously in the Food Stamp and Food Distribution programs.
4. Do not commit any act that violates a federal statute or regulation relating to the acquisition or use of Food Distribution Program commodities.

If you or any member of your household knowingly and willingly violates the rules above it is considered an Intentional Program Violation (IPV). Household members determined to have committed an IPV will be ineligible to participate in the Food Distribution Program for a period of 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. Individual(s) committing an IPV may be referred to authorities for prosecution.

Authorization: I authorize the release of any necessary information or forms to the Food Distribution Office to determine/verify my eligibility. I understand this information will be used for the purpose of documenting my eligibility for the Food Distribution benefits. This authorization is good for 12 months from the date signed.

CERTIFICATE 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 falsification of the information on this form may be grounds for disqualifications and/or claim action. I further understand that I must report any changes in household size, income and/or resources to the Food Distribution Office within 10 days of the date changed becomes known.

Applicant Signature _____ Date _____

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