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

_____

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

_____

_____

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.

**CIRTIFICATE 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 _____