Fort Belknap FDPIR Commodity Program
203 Food Farm Ave
PH#: 406-353-8487 / 8403 / 8407
FX#: 406-353-2546

Client Responsibilities.

You CAN NOT receive COMMODITIES and SNAP BENEFITS in the same month.

Application must have all Social Security Numbers for all household members.
Must have your Physical Address and P.O. Box if you have both.

- **RELEASE OF CONFIDENTAL INFORMATION FORM:**
  MUST be **SIGNED** by **ALL** household members 18 years of age.

- **ZERO INCOME FORM:**
  All household members who **DO NOT** have any income **MUST SIGN** this form.

- **SOCIAL SECURITY FORM:**
  Only household members that receive Social Security or Supplemental Security or BOTH must fill out and sign this form Or *if you have a current copy of your SS/ SSI please attach to the application.*

- **INCOME for All Household members:**
  Attach verification of INCOME for the past 30 days to the application.
  Earned or Unearned Income such as
  (Wages, GA/TANF, Voc-Rehab, Pell, etc...)

- **Sign and Date the application the day it is brought into the office.**

INCOMPLETE APPLICATION WILL BE RETURNED TO APPLICANT.

If you are late, you will not be able to receive your commodities until the next business day.

Any questions or comments, call the Montana State Office:

Carie Kelly @ 406-477-4262 or Tina Wagner @ 406-447-4263

OPA PH#: 1-888-706-1535

DPHHS-FD-001
(Rev. 11/13)

STATE OF MONTANA
Department of Public Health and Human Services

FOOD DISTRIBUTION APPLICATION

OFFICE USE ONLY
Case No.:
I.D. No.:
Expiration Date:
County: Loc:
No. in Household:

APPLICANT: COMPLETE THIS SECTION

NAME (Head of Household)

ADDRESS

CITY, STATE, ZIP CODE | DATE OF BIRTH

PHONE NO. | SOCIAL SECURITY NO.

Racial Ethnic Heritage: Although you are not required to provide this information, your cooperation would be appreciated. If you decline to provide this information, it will in no way effect consideration of your application. Enter appropriate number of household members in each category.

Black (Non-Hispanic) B____ White (Non-Hispanic) W_____

Hispanic H _____ Asian (or Pacific Islander) A_____

American Indian/Alaskan Native I _____

APPLICANT: COMPLETE THIS SECTION

Is any member of this household currently certified to receive Supplemental Nutrition Assistance (SNAP)? ❑ Yes ❑ No

Is any member disqualified from the SNAP Program because of fraud, or disqualified from FDPIR? ❑ Yes ❑ No

Has this household received any income in the present month? ❑ Yes ❑ No

Does this household reside within the Food Distribution Service Area? ❑ Yes ❑ No

How many members of this household receive an AFDC or SSI grant? _____

Monthly shelter and utility expenses

Rent/Mortgage	❑ Yes	❑ No
Property taxes	❑ Yes	❑ No
Electricity	❑ Yes	❑ No
Gas/Propane	❑ Yes	❑ No
Sewer	❑ Yes	❑ No
Trash Collection	❑ Yes	❑ No
Phone	❑ Yes	❑ No
Septic Maintenance	❑ Yes	❑ No

Monthly non-reimbursed out of pocket medical expenses over $35

Medical/Dental
Prescriptions
Ins/Medicare premiums
Home Health Care
Medical related transportation

See certification clerk for complete list of allowable deductions

List household members below	List Social Security Nos. for each Household member	Date of Birth	Status Code	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	
5.	5.	5.	5.	
6.	6.	6.	6.	
7.	7.	7.	7.	
8.	8.	8.	8.	
9.	9.	9.	9.	
10.	10.	10.	10.	
11.	11.	11.	11.	
12.	12.	12.	12.	
13.	13.	13.	13.	

Status Codes
M – Moved
D – Deceased
I – Ineligible
S – SNAP
X – Delete

Are there any individuals living with this household who provide payment to the household for lodging but not for meals?
❑ Yes ❑ No If yes, give names: _____

Do all of the individuals listed above purchase and prepare their meals together: ❑ Yes ❑ No

OFFICE USE ONLY

If the household is not certified for SNAP in the present month and lives within the Food Distribution Service Area they are automatically eligible if 1 **or** 2 applies.

1. Household has no income nor anticipates any for the current month.
2. All household members received an AFCD or SSI grant.

If the household has no income, or if the household is likely eligible and would otherwise suffer hardship, the household may receive expedited services at the discretion of the local agency. Identity and address must be verified prior to any distribution of commodities

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PENALTIES FOR FRAUD: The State and Federal laws provide penalties, including a fine, imprisonment, or both, for persons found guilty of obtaining donated foods for which they are not eligible by making false statements or

FAILING TO REPORT PROMPTLY any changes in their circumstances. If evidence that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.

ANY WHO AIDS another person to obtain donated foods fraudulently is subject to the same penalties.

I UNDERSTAND that I have the right to a fair hearing if I am not satisfied with the action taken on my application by the Food Distribution Office.

CONFIDENTIALITY: The use of disclosure by any party of any information concerning a client in violation of any rule of confidentiality or for any purpose not directly connected with the administration of the Department's or the Council's responsibilities with respect to the Food Distribution Program is prohibited, except on written consent of the client, his parent if he is a minor, or his court-appointed guardian.

CIVIL RIGHTS: The U.S. Department of agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint or discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust. html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D. C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

USDA is an equal opportunity provider and employer.

APPLICANT: READ ABOVE AND COMPLETE SECTION BELOW

I hereby authorize the following individuals to act as my Authorized Representatives.

NAME _____ NAME _____

I certify that this application has been explained to me (or examined by me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the Food Distribution Office necessary information to verify any statements given in this application and give permission to obtain such verification. I will also cooperate fully with State and Federal personnel in a quality control review.
I agree to inform the Food Distribution Office promptly (Within 10 days) of changes in income, living arrangements or other information which I have given, since changes may affect eligibility to receive donated foods.

Signed: _____ Date: _____
(Signature of applicant or authorized representative)

OFFICE USE ONLY

CERTIFICATION ACTION:

Status Code Date _____

Status Code _____

APPROVED from: _____ through _____

DENIED: (Reasons) _____

Status Codes
M Moved
D Deceased
I Ineligible
S SNAP
X Delete

Signature: _____ Date: _____
(Certifying Clerk)

CHECK APPROPRIATE BOX(ES)	Approved for expedited services ☐ Yes ☐ No	Attachment Part II - ☐ Yes ☐ No Attachment Part III - ☐ Yes ☐ No

DPHHS-FD-001A
(Rev. 11/13)

STATE OF MONTANA
Department of Public Health and Human Services
"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

NAME	SOCIAL SECURITY NUMBER	CASE NO.

ADDRESS	CITY	COUNTY	ZIP

PART II INCOME STATEMENT (Reference FNS 501 Sections 4600-4640)

Section A Earned Income (Reference FNS 501 Section 4520)

SUBSECTION A-1 CONTRACT & SELF-EMPLOYMENT INCOME (Reference FNS 501 Section 4720-4727)

List all *gross income before taxes* from self-employment, to include payment from roomers and returns on rental property for each household member

NAME	SOURCE	AMOUNT	HOW OFTEN RECEIVED	FOR OFFICE USE ONLY
		$		Amount to average $
				Amount to average $
				Amount to average $
A. ENTER TOTAL HERE		$		D. Total to average $

List all *net profits* from the sale of capital goods or equipment within the last 12 months and enter dates of sale.

ITEMS	AMOUNT	DATE	FOR OFFICE USE ONLY
	$		Amount to average $
			Amount to average $
B. ENTER TOTAL HERE	$		E. Total to average $

List business expenses and give dates expenses were incurred for the last 12 months

ITEMS	AMOUNT	DATE	FOR OFFICE USE ONLY
Labor	$		Amount to average $
Stock and Raw Material (seed, fertilizer, etc.)			Amount to average $
Insurance Premiums (equipment, etc.)			Amount to average $
Property Taxes			Amount to average $
Other (Identify)			Amount to average $
			Amount to average $
C. ENTER TOTAL HERE	$		F. Total to average $

FOR OFFICE USE ONLY

If income listed in Subsection A-1 is the households only means of support, the income must be averaged over a 12 month period, even if the income is received in a shorter period of time. If income in A-1 represents only a part of the household's support, it should be averaged over the period of time it contributes support to the household. If the receipt of income in Sections A & B is reasonably certain, but amounts fluctuate, income may be averaged if it is to the benefit of the household.

Review A & B to determine if income is to be averaged.
If income is to be averaged, determine the number of months in the averaging period.
Calculate the amounts in Subsection A-1 that apply to the averaging period and enter these amounts in D, E & F in the same subsection

1. If income is to be averaged, enter averaging period: From _____ to _____
2. Enter number of months in averaging period (if applicable): ..... Number of Months: $ _____
3. Add D and E in Subsection A-1 and enter the sum: ..... $ _____
4. Enter the amount from F in Subsection A-1 ..... $ _____
5. Subtract the amount on Line 4 from the amount on Line 3: (No less than 0) ..... $ _____
6. Divide the amount on line 5 by number of months on Line 2: ..... $ _____

SUBSECTION A-2 TRAINING ALLOWANCES (Reference FNS 501 Section 4520C)

Training Allowances				

1. Enter monthly income received ..... _____
2. Enter monthly tuition and mandatory fees ..... _____
3. Subtract line 2 from line 1 (if amount is negative, enter 0) ..... _____ $

SUBSECTION A-3 WAGES, SALARIES & OTHER INCOME FROM EMPLOYMENT

Wages, Salaries or Other Income from Employment						X	Factors Used	
NAME		SOURCE		AMOUNT		X		
						X		
						X		

(Use conversion factors FNS 501 Section 4621) Total monthly wage and salary income and enter the total on this line $

Section B Unearned Income (Reference FNS 501 Section 4530)

SOURCE OF INCOME

1. SSI (Supplemental Security Income) -- Gold Checks	9. Other (specify)
2. AFCD (Aid to Families with Dependent Children)	10. Land Lease
3. GA (General Assistance)	11. Pasture Lease
4. Social Security -- Blue/Green Checks	12. Farm Lease
5. Pensions or retirement income	13. Oil or Gas Lease
6. Money from friends or relative (other than loans)	14. Other Leases (specify)
7. Child support and alimony	15. Other Leases (specify)
8. Unemployment or Workers' Compensation	16. Per Capita Payments (specify)

Indicate household member receiving payment and identify payment by above numbers

NAME	NO.	AMOUNT	HOW OFTEN RECEIVED	CIRCLE CONVERSION FACTOR	MONTHLY TOTAL
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				1 - 2 - 2.5 - 4 - 4.3	
				ENTER TOTAL $	

Section C Income Deductions

If you pay for child care or other dependent care to enable you to accept or continue work or attend training which is preparatory to employment, enter the monthly amount. Do not enter if these amounts are paid to a member of your household. $ _____

Recurring monthly out of pocket medical deduction - over $35 $ _____

Legally required child support payments $ _____

Premium for Medicare Part B $ _____

Housing/utility standard deduction ($400) $ _____

Total $ _____

Signature _____ Date _____

(Applicant or Authorized Representative)

FOR OFFICE USE ONLY

7.	Enter self-employment amount from line 6 on reverse side	7	$
8.	Enter total monthly amount from Subsection A-2 on reverse side	8	$
9.	Enter total monthly amount from Subsection A-3 on reverse side	9	$
10.	Add lines 7, 8 and 9 and enter total earned income	10	$
11.	Enter 20% of line 10. (Earned income standard deduction)	11	$
12.	Subtract amount on line 11 from amount on line 10 (Net earned income)	12	$
13.	Enter total monthly unearned income from Section B above	13	$
14.	Add amounts from lines 12 and 13. (Total earned and unearned)	14	$
15.	Enter total from Section C, Income Deductions	15	$
16.	Subtract amount on line 15 from amount on line 14	16	$

17. Use the amount on line 16 to determine eligibility.

18. On line 19 and 21 enter the number of each month used for each period beginning with 1.
On line 20 enter the amount under the month, a lump sum payment is expected.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
19. Averaging Period												
20 Lump Sum Payment												
21 Certification Period												

Signature _____ Date: _____

(Certification Clerk)

Attach to DPHHS-FD-001

DPHHS-FD-012
(Rev. 3/09)

STATE OF MONTANA
Department of Public Health and Human Services
Human and Community Services Division
Food Distribution Section

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name: _____ Social Security Number: _____

Address: _____
(Street) *(City)* *(State)* *(Zip Code)*

I authorize the individual, company or agency shown below to disclose to the Needy Family Program Commodity Office, the information specified below, which relates to my eligibility to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SHOULD BE RETURNED TO THIS ADDRESS	COMMODITY PROGRAM 203 FOOD FARM AVE FAX: 353-2546 HARLEM, MT 59526

INFORMATION SOURCE:

OPA

477

FBIC/IMDG

INFORMATION TO BE REQUESTED:

PA - SNAP

GA - TANF

WAGES

INSTRUCTIONS:

This is a 4-page N.C.R.
Send one (1) copy to each information source.
Keep at least one (1) copy in the client's file.

Signature of applicant or person signing in his/her behalf:

X_____ Date: _____

Public Health & Human Services – PO Box 202956, Helena MT 59620-2956

In accordance with federal law and USDA Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800)795-3272 (voice) or (202)720-6382 (TDD). USDA is an equal opportunity provider and employer.

ZERO INCOME FORM

In determining your eligibility for the Food Distribution Program, you must provide proof of income for the 30 days prior to the date of application. If you had ZERO income for the past 30 days, you must answer the following questions.

(EACH HOUSEHOLD MEMBER THAT DOES NOT HAVE ANY INCOME MUST FILL OUT AND SIGN BELOW.)

1) What was the total income for your household for the past 30 days?

   _____

2) How do you pay utility bills?_____
3) How do you pay rent?_____
4) How do you get food for your household?_____
5) Are you receiving income from friends or family?_____ How much?_____
6) Are you looking for work?_____
7) Have you applied for PA or GA?_____
8) If you are residing with others (such as family or friends), do you purchase, prepare and eat separately?_____

I hereby certify that the information I have provided accurately represent the total income for each member of my household.

PRINT NAME:_____
SIGNATURE_____ Date: _____

PRINT NAME:_____
SIGNATURE_____ Date: _____

PRINT NAME:_____
SIGNATURE: _____ Date: _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-05

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

***ADDRESS OF PERSON OR ORGANIZATION:**

Fort Belknap Commodity Program
203 Food Farm Ave
Harlem, Mt 59526 PH: 406-353-8403/8487

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examine all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowin or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on t signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

DPHHS-FD-001C (REV 12/11)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

PENALTIES FOR INTENTIONAL PROGRAM VIOLATIONS

(EFFECTIVE FEBRUARY 28TH, 2000)

EFFECTIVE FEBRUARY 28TH, 2000 ANY APPLICANT OR HOUSEHOLD MEMBER KNOWINGLY, WILLINGLY, AND WITH DECEITFUL INTENT:

1) **MAKES A FALSE OR MISLEADING STATEMENT, OR MISREPRESENTS, CONCEALS, OR WITHOLDS FACTS IN ORDER TO OBTAIN FOOD DISTRIBUTION BENEFITS WHICH THE HOUSEHOLD IS NOT ENTITLED TO RECEIVE; OR**

2) **COMMITS ANY ACT THAT VIOLATES A FEDERAL STATUTE OR REGULATION RELATING TO THE ACQUISITION OR USE OF FOOD DISTRIBUTION PROGRAM COMMODITIES;**

3) **WILL BE INELIGIBLE TO PARTICIPATE IN THE FDPIR PROGRAM FOR:**

   a) **12 months for the first violation;**
   b) **24 months for the second violation;**
   c) **Permanently for the third violation.**

ALL SUBSTANTIATED CASES OF (IPV) INTENTIONAL PROGRAM VIOLATIONS MUST BE REFERRED TO TRIBAL, FEDERAL, STATE, OR LOCAL AUTHORITIES FOR PROSECUTION UNDER APPLICABLE STATUTES.

I HAVE READ AND FULLY UNDERSTAND THE PENALTIES FOR THE ABOVE VIOLATIONS.

NAME OF APPLICANT (PLEASE PRINT):_____

SIGNATURE OF APPLICANT:_____

SIGNATURE DATE:_____