

Date: _____

Client ID#: _____

DS: _____

TEFAP CSFP

APPLICATION FOR BENEFITS

APPLICANT INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

GENDER (Optional):

Male Female Transgender Undisclosed Other

MARITAL STATUS (Optional):

Single Married Divorced Separated Widowed Undisclosed Common-Law

ADDRESS (No., Street) _____

CITY _____ COUNTY _____ STATE _____

ZIP CODE _____ PHONE NUMBER _____ No Fixed Address/Undisclosed

HOUSING TYPE (Optional):

Emergency Shelter/Mission/Transitional Evacuee Unhoused Own Home Private Rental
 Public (Social) housing With Family/Friends Youth Home/Shelter Undisclosed Other

LANGUAGE (Optional): _____

ETHNICITY: (Ethnicity is REQUIRED for CSFP) White/Anglo Black/African American Hispanic/Latino

Pacific Islander Asian N/A American Indian/Native American Alaska Native/Aleut/Eskimo Middle Eastern/North African Other Undisclosed

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
- Transgender
- Undisclosed
- Other

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
- Transgender
- Undisclosed
- Other

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
- Transgender
- Undisclosed
- Other

APPLICANT IS RECEIVING THE FOLLOWING

- Supplemental Nutrition Assistance Program (SNAP)
- Commodity Supplemental Food Program (CSFP)
- Other (Specify):

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, disability, age 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.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. 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.