CASE # _____

COMMODITY SUPPLEMENTAL FOOD PROGRAM

COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

Please complete one application for each person you are enrolling on the program.

Name _____ Date of Birth _____ Verified by _____

Address _____ City _____ ZIP _____ Verified by _____

County _____ Home Phone _____ Work Phone _____

CIRCLE ONE OR MORE: (For civil service statistical purposes only) Are you Hispanic or Latino? ____Yes ____No

1) American Indian or Alaskan Native 2) Asian 3) Black or African American 4) Native Hawaiian or Other Pacific Islander 5) White

IS THE APPLICANT:

☐ Female ☐ Male Social Security Number _____

ADULTS ONLY(Circle one): Single Married Divorced Separated Widowed

List persons authorized to pick up your food-no more than two (2): _____

How many persons live at your address? _____ Are you living with a friend or relative? ☐ Yes ☐ No

List all persons living in your home and include income for each person working or receiving benefits.

Names of those WORKING **Hours worked** **Amount Gross**

_____ Hour Week Biweek Month Year

_____ Hour Week Biweek Month Year

Names of those NOT WORKING, RETIRED, CHILDREN-OTHER THAN YOURSELF

_____

_____

LIST DOLLAR AMOUNTS OF ANY OTHER INCOME (before deductions):

TAF _____ Social Security _____ Food Stamps _____ Disability /SSI _____

Unemployment _____ Pension/Retirement_____ DCF/General Asst._____ Foster Care Pay _____

Military Pay _____ Self-Employed _____ Child Support _____ Interest Income _____

Other _____ Verified by_____

Has the applicant been on CSFP before? ☐ Yes ☐ No

Is the applicant, or any others living in the home Migrant Workers? ☐ Yes ☐ No In a homeless shelter? ☐ Yes ☐ No

By reading, signing and dating the back of this form, I acknowledge that the information provided is accurate and complete. I also understand that I must notify CSFP of all changes of income, address or household composition within 10 days.

This institution is an equal opportunity provider.

Please mail completed forms and the following back to us:

ID or Driver's License and proof of income, ie Social Security Statement (please note we cannot accept bank statements for proof of income)

Mail to: **Kansas Food Bank**
1919 E Douglas, Wichita KS 67211

Rev 10/2015

YOUR RIGHTS AND RESPONSIBILITIES IN THE KANSAS COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

I AGREE TO:

- ✓ Bring proof of income, address, and identification for each person applying.
- ✓ Give staff correct information about my current household and their income.
- ✓ Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

I UNDERSTAND THAT:

- ✓ CSFP will provide supplemental foods.
- ✓ CSFP will provide referrals to nutrition, health or assistance programs as appropriate.
- ✓ The CSFP local agency will provide nutrition education to all program participants.
- ✓ I will be dropped from this program if I participate in another CSFP Program.
- ✓ I have the right to appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.
- ✓ If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
- ✓ I may be taken off the program if I sell, trade, or give away CSFP foods.
- ✓ I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- ✓ I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- ✓ I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- ✓ Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits, and may lead to disqualification from CSFP.

This application form 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 statues. I am also aware that I may not receive CSFP benefits at more than once CSFP site at the same time. I am also aware that I may not receive CSFP benefits more than once a month at another site of CSFP.

Furthermore, 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 ☐

_____ _____

Signature of Participant, Adult Parent, or Caretaker Date

This institution is an equal opportunity provider.

Rev. 10/2015

CSFP Client Name:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

Do you have an email address:

_____

What Apartment Complex Do You Live At:

_____

Name of Manager:_____

Phone #:_____

Can we call the manager if you do not pick up your box? _____