APPLICATION FOR ALASKA COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

CSFP Partner Agency: _____ Date Received____/____/____

(ONE APPLICATION PER PERSON)

APPLICANT: The Applicant's eligibility for CSFP is based upon the following statements. A separate application is required for each Applicant.

Are you 60 years old or older?	☐ YES ☐ NO

Please print and complete all information.

Name of Applicant: _____ Birth Date_____/_____/_____
(Last) (First) (Middle) MM DD YYYY

Mailing
Address: _____, AK ZIP_____
Street or PO Box Apt # City

Physical
Address (if different): _____, AK ZIP_____
Street or PO Box Apt # City

Home Phone_____ Cell Phone_____ Message Phone _____

ID Verification: ☐ Birth Certificate ☐ Driver License ☐ ID Card ☐ Other (Please specify): _____

What is your race? (Please **choose one or more**) ☐ Alaska Native/American Indian; ☐ Asian;
☐ Black; ☐ Native Hawaiian/Pacific Islander;
☐ White; ☐ Not Hispanic or Latino

Racial and/or ethnic data collected on this form has NO EFFECT ON THE ELIGIBILITY DETERMINATION OF THE HOUSEHOLD.

Primary language: _____ How many people in your household? _____

☐ Please select if you self-declare that you meet the income guidelines to participate in the CSFP Program.

Did anyone in your household receive the latest AK Permanent Fund Dividend? ☐ Yes ☐ No If yes, how many? _____
(Your PFD or other garnished income is considered income even though it is garnished and must be added to your total household income.)

Do you meet the Income Eligibility Guidelines for CSFP? ☐ YES ☐ NO	Total Income: _____ ☐ M ☐ Y

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.

Before signing, know your rights and responsibilities under the Commodity Supplemental Food Program (CSFP). By signing below the statements listed below, I am saying that I understand: (Reading help is available.)

- 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. I am also aware that I may not receive CSFP benefits at more than one CSFP site at the same time. 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 check mark in the appropriate box.) **☐ yes ☐ no**
- The local agency will provide notification of a decision to deny or terminate CSFP benefits within 10 days of applications. If you disagree with the denial or termination of assistance, **you can request a Fair Hearing within sixty (60) days from the date the agency mails or gives the individual notification of adverse action,** by contacting State of Alaska Family Nutrition Programs at 130 Seward Street, Room 508, Juneau, Alaska 99801; or call 907 465-3100. A request for a Fair Hearing shall be personally presented, either orally or in writing. A request for an informal review must include: 1) name, address and contact phone number, 2) the reason for the grievance, 3) the action or relief sought, and 4) signature of applicant or representative. A Hearing Officer will arrange a date, time, and place convenient to both you and Family Nutrition Programs. In preparing for the hearing, you have the right to examine any documents, including records and regulations that ae directly relevant to the hearing. You have the right to be represented by counsel or any other person chosen as your representative. You have the right to a private hearing unless you request a public hearing. You have the right to present evidence and arguments in support of your grievance and to controvert evidence. You also have the right to cross-examine all witnesses. The Hearing Officer must render a decision within (14) days of the hearing. The decision of the Hearing Officer will be final.
- The local agency will make nutrition education available to all adult participants and will encourage them to participate.
- The local agency will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits and may lead to disqualification from CSFP.
- I must report changes in household income or composition within 10 days after the change becomes known to the household.
- I agree to inform the CSFP partner agency within 10 days of any changes in my contact information (i.e. my home address or phone number), my income, or my household composition.
- If I do not pick up my commodity foods for two months in a row, I may be considered an “inactive” CSFP participant and removed from the program. If I choose to remain a participant in CSFP, I must notify the CSFP partner agency and participate within the current certification period of my original application date.
- CSFP recipients who are removed from the program for being “inactive participants” are allowed to re-apply for benefits by filling out another CSFP application. If a waiting list exists, however, I understand my application will go on the list according to the date it was received.
- I must fill out a new CSFP application once every three years. Once a year, I will need to verify my address, income, and my interest in continuing with the program.
- I will treat all CSFP staff with courtesy and respect. Failure to do so may result in termination of assistance.

APPLICANT OR Guardian/POA Agent: _____
Signature Date

Printed Name of Applicant or Guardian/POA Agent: _____

My Approved Proxy(s) (full name): _____
If you would like to give permission for someone to pick up your CSFP food box or when, in season, your yearly senior farmer’s market nutrition program vouchers on your behalf, please name them here.

CSFP Agency Use Only: If an application is signed by someone other than the applicant, CSFP regulations require CSFP agencies to see Power of Attorney paperwork.

Power of Attorney paperwork reviewed by the Certifying Official? ☐ Yes ☐ No Certifying official initials :____

Status	Date	Eligible	End Date	Initials of Official
Wait List	___/___/___	☐ Yes ☐ No	___/___/___	
Temporary/Suspended	___/___/___	☐ Yes ☐ No	___/___/___	
1. Certification	___/___/___	☐ Yes ☐ No	___/___/___	
2. Recertification	___/___/___	☐ Yes ☐ No	___/___/___	
3. Termination	Reason:			
Notification Given	☐Yes	☐No	Verbal	Written