Alabama Commodity Supplemental Food Program [CFDA. 10.565]
Montgomery Area Food Bank Network.

SELMA AREA FOOD BANK

SELMA AREA FOOD BANK CSFP PARTICIPANT APPLICATION

Household Information: To be completed by the applicant or authorized representative			
Applicant Name (Last, First, Middle Initial):	**Phone Number**:		**Application Date**:
Street Address (Include Apt # if applicable):	**City**:	**Zip:**	**State**: / **County**:
Date of Birth (MM/DD/YY): / **Current Age**:	**Total Household Gross Income** (before deductions): $_____		
Household Size (Total number of household members, including applicant): _____	☐ Annual ☐ Monthly ☐ Twice Per Month ☐ Every 2 Weeks ☐ Weekly ☐ No Income		

CSFP Income Guidelines 2019 (130% of poverty rate)

I hereby certify that my household income is at or below the following guidelines. ☐ Yes ☐ No

Household Size	Annual Income	Monthly Income	Twice Per Month	Every Two Weeks	Weekly Income
1	$16,237	$1,354	$677	$625	$313
2	$21,983	$1,832	$916	$846	$423
3	$27,729	$2,311	$1,155	$1,067	$534
4	$33,475	$2,790	$1,395	$1,288	$644
5	$39,221	$3,269	$1,634	$1,509	$755
6	$44,967	$3,748	$1,874	$1,730	$865
7	$50,713	$4,227	$2,113	$1,951	$976
8	$56,459	$4,705	$2,352	$2,172	$1,086
For each additional HH member, add:	$5,746	$479	$239	$221	$111

Ethnic/Racial Data: For Statistical Purposes ONLY

Ethnic Category (Select one):
Are you Hispanic or Latino?
☐ Yes ☐ No

Racial Category (Select one or more):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Prefer not to Disclose

Proxy Information: A proxy is a person the applicant may authorize to pick up the CSFP food packages on their behalf for a specified time period. The proxy must be at least 18 years of age and must bring proof of his/her identification to pick up the CSFP food package. If you would like to designate a proxy, please complete the information below.

Name of Proxy (Must be at least 18 years of age):

Designated Time Period for CSFP Food Pick Up (Month/year):

OFFICIAL USE (Local Agency Staff/Volunteers)

Eligibility Criteria: ☐ Age ☐ Income ☐ County of Residence Applicant's Identification was Confirmed ☐

Verification Source(s) for Identification, Age and County of Residence: ☐ Driver's License ☐ State-Issued ID ☐ Other _____

Document Name (If other): _____

LA Staff/Volunteer Printed Name:
_____

LA Staff/Volunteer Staff's Signature: _____ Date: _____

CONTINUE TO BACK

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OFFICAL USE (To be completed by Local Agency Staff Only)		
Status: ☐ Eligible (Active List) ☐ Eligible (Waiting List)	**Method of Notification:** ☐ Verbal ☐ Letter	**Date of Notification:**
Initial Certification Period: From _____ to _____ **If applicable: Date Certified as Active from Wait List:**	**Re-Certification Period:** 1. From _____ to _____ 2. From _____ to _____	**Re-Certification Dates of Notification** 1. _____ 2. _____
Status: ☐ Ineligible ☐ Discontinued ☐ Disqualified ☐ Terminated	**Date of Written Notification:**	
Ineligible/Discontinued/Disqualified/Terminated-Reason:		
LA Staff's Name (Print): _____ **Title:** _____ **LA Staff's Signature:** _____ **Determination Date:** _____		

Non-Discrimination Statement: "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".

Certification: 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 checkmark in the appropriate box.) ☐ YES ☐ NO

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APPLICATION INSTRUCTIONS: Complete application in black or blue ink only.

To Be Completed by the Applicant or Authorized Representative

Applicant Name	List applicant's last name, first name and middle initial.
Telephone Number	List applicant's area code and telephone number.
Application Date:	List the date of application.
Street Address	List applicant's street address and if applicable, apartment number.
City	List applicant's city of residence.
Zip Code	List applicant's zip code.
County	List the applicant's county of residence.
Date of Birth	List applicant's month, day and year of birth.
Current Age	List applicant's age.
Total Household Gross Income and How Often is Received	List the total household gross income (before deductions) and check the box for how often income is received (i.e., weekly, monthly, etc.). If no one in the household receives income, check the No Income box.
Household Size	List the total number of household members, including applicant.
Income Certification	Check either Yes or No to certify the household income is within the allowable guideline limits. Check Yes, if applicant cannot provide proof of income and self declares that their household income is below 130% of the current income poverty guidelines.
Ethnic & Racial Data	This question is optional for the applicant. Please select one Ethnicity, then select one or more Race categories. Applicant may also select "Prefer not to disclose".
Proxy	Complete only if authorizing an individual to obtain the CSFP food kits on the applicant's behalf. Provide the proxy's name and the time period in which the applicant designates the individual as a proxy.
Certification Statement	Read the certification statement and check either Yes or No.
Signature of Applicant/ Authorized Representative	The person for whom CSFP benefits are being requested must sign the application. If the application is being made by an authorized representative, the authorized representative may sign on behalf of the applicant.
Signature Date	List the date the application is signed.

Official Use - To Be Completed by Local Agency Site Staff/Volunteer Only

Eligibility Criteria/ Applicant Identification	Once the applicant's eligibility criteria and identification have been verified/confirmed, check all applicable boxes. If any box cannot be checked as applicable, the applicant is not eligible for participation.
Verification Source(s)	Check the applicable box(s) for the verification source(s) used to verify/confirm the applicant's identification, age and county of residence (i.e., driver's license, State-issued ID, etc.). If Other is checked, list the document name (i.e. passport, birth certificate, Medicare Card, etc.). A Social Security card is not an acceptable source of verification.
LA Staff/Volunteer Printed Name	Print the name of the designated Local Agency staff/volunteer verifying the information on the application.
LA Staff/Volunteer Signature/Date	Provide the signature of the designated Local Agency staff/volunteer and date the application is received or taken.

Official Use - To Be Completed by Local Agency Staff Only

Status - Eligible Active, Waiting List	Check the applicable box.
Method of Notification/Date	Check the applicable box and provide the date of notification.
Initial Certification Period	Provide the date of the original certification period.
Re-Certification Period/Date	If applicable, provide the re-certification period and the date the applicant was notified of their re-certification.
Date Certified as Active from Waiting List	If applicable, provide the date the participant was certified as Active from the Waiting list.
Status- Ineligible/Discontinued, Disqualified, Terminated - Reason/Date	Check the applicable box and provide the date the written notification was provided.
LA Staff Printed Name/Title	Print Name and title of LA Staff.
LA Staff Signature/Date	The LA Staff making the eligibility/ineligibility determination must sign and provide the date the eligibility/ineligibility determination was made.

SELMA AREA FOOD BANK

CSFP

Commodity Supplemental Food Program

NO-SHOW POLICY

As part of the Commodity Supplemental Food Program (CSFP) food packages should be collected from the designated locations every month. Each participant shall be given the time and location of their monthly pickup. If a participant fails to pick-up their box in a month's time, the participant shall be considered a "no-show."

Violation of the "no-show" policy shall result in forfeiture of CSFP benefits.

The CSFP No-Show policy is as follows:

1. Participant's failure to pick-up food packages for two (2) consecutive months will be removed from enrollment in CSFP.

2. Participants in hospital, out of town, or unable to pick-up the food package due to illness for two (2) consecutive months may remain on the program and will not be removed, as long as they contact the Food Bank at _____.

3. Participants who are removed from the program for violation of the "no-show" policy are allowed to reapply for benefits unless they have violated the "no-show" policy twice previously. If a wait list exists, participants re-applying after violating the "no-show" policy must be treated as if they were applying for the first time and must be placed on the wait list in the order in which they contacted the Food Bank.

4. Participants who violate the "no-show" policy a third time within a twelve (12) month period must be disqualified from CSFP for a period of up to one year, unless the local agency determines that disqualification would result in a serious health risk.

5. Participants in violation of the "no-show" policy have a right to request a fair hearing by contacting their local CSFP agent at _____. Participants have thirty days (30) from the date of written notice to request a fair hearing.

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CSFP

Commodity Supplemental Food Program

YOUR RIGHTS AND RESPONSIBILITIES IN THE Montgomery Area Food Bank (MAFB) COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

I AGREE TO:

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

I UNDERSTAND THAT:

1. CSFP will provide supplemental foods.
2. CSFP will provide referrals to nutrition, health or assistance programs as appropriate.
3. The CSFP local agency will provide nutrition education to all program participants.
4. Income documentation is not required and shall not be maintained on file as my signature self-declares validity of the income.
5. I will be dropped from this program if I participate in another CSFP Program.
6. 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.
7. If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
8. I may be taken off the program if I sell, trade, or give away CSFP foods.
9. I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
10. I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
11. I may be taken off the program if I verbally or physically abuse or threaten to physically abuse program staff.
12. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me 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 statutes.

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