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2014-2015 MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

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

RETURN THIS APPLICATION TO THE AGENCY ON AGING THAT SUBMITTED TO YOU.

Name _____ **Date of Birth** _____

Address _____ **City** _____ **ZIP** _____

County _____ **Home Phone** _____ **Work Phone** _____

Please indicate ONE OR MORE: (For civil service statistical purposes only) Are you . . .

1) American Indian or Alaskan Native ☐ **Yes** ☐ **No**

2) Asian ☐ **Yes** ☐ **No**

3) Hispanic or Latino ☐ **Yes** ☐ **No**

4) Black or African American ☐ **Yes** ☐ **No**

5) Native Hawaiian or Other Pacific Islander ☐ **Yes** ☐ **No**

6) Caucasian ☐ **Yes** ☐ **No**

IS THE APPLICANT:

- Is the applicant 60 years old or older? ☐ **Yes** ☐ **No**
- Is the applicant currently receiving any benefits under the WIC (Women, Infants, & Children) Program**?** ☐ **Yes** ☐ **No**
- Is the applicant living with a friend or relative? ☐ **Yes** ☐ **No**

INCOME:

	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
1	$292	$575	$2,530	$1,265	$15,171
2	$394	$776	$3,410	$1,705	$20,449
3	$495	$976	$4,288	$2,144	$25.727
4	$597	$1,178	$5,168	$2,584	$31,005
5	$698	$1,378	$6,048	$3,024	$36,283
6	$800	$1,580	$6,928	$3,464	$41,561

How many persons live at your address and make up your family unit? _____

Is the applicant's gross family unit income less than the amount listed? ☐ **Yes** ☐ **No**

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

Is the applicant currently receiving CSFP? ☐ **Yes** ☐ **No**

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

I AGREE TO:

- Provide proof of my income, address, and identification if requested.
- 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 or WIC 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.

CERTIFICATION

This application form is being completed in connection with receipt of Federal Assistance. I am aware that program officials may need to verify information on this form and that I am obligated to cooperate. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

I certify that I will not receive both CSFP and WIC benefits simultaneously, and I will not receive CSFP benefits at more than one CSFP site concurrently. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation.

I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

☐ **By checking this box I am indicating that I do not want my personal information released to other organizations administering assistance programs for use in determining my eligibility for participation in this and other public assistance programs and for program outreach purposes. I understand that this may result in my not being approved for this program.**

By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete and that I am not receiving any WIC benefits. I understand that I may not receive WIC and CSFP benefits at the same time and that I must notify CSFP of all changes of income, address or household composition within 10 days.

Signature: _____ **Date:** _____

Any questions please contact the agency that provided this application.

STAFF USE ONLY: **Certifying Action Taken**

Approved _____ **For period ending last day**_____

Date Put on Waiting list if necessary_____

Denied _____ **Letter of Fair Hearing Given**_____

Date_____ **Signature of Verifying & Determining Official** _____