

Application for Commodity Supplemental Food Program

Office Use Only

Pick Up Place _____

Pick Up Day _____

Termination Date _____

Name of Applicant: _____
(Last) (First) (Middle Initial) (Date of Birth) (Age)Guardian: _____
(Last) (First) (Middle Initial)Address: _____ AK _____
Street or PO Box City Zip

Home Phone: _____ Message Phone: _____

Race/Ethnicity: Alaska Native/American Indian White
 Black/African American Asian/Pacific IslanderHispanic or Latino? Yes No How many people in your household? _____

Total Household income before deductions: _____ per _____ (week, month, year)

Are you on any of these programs? WIC: yes no Medicaid: yes no
Food Stamps: yes no ATAP: yes no

Before signing, be aware of your rights:

- Standards for CSFP are the same for everyone regardless of race, color, national origin, sex, age, or disability.
- To file a complaint of discrimination, write: USDA, Director; Office of Civil Rights; Room 326-W, Whitten Building; 1400 Independence Avenue, S.W.; Washington D.C. 20250-9410 or call (202) 720-5964 (Voice and TDD). USDA is an equal opportunity provider and employer.
- I understand my rights and obligations under CSFP. The information I have provided is correct, and the CSFP staff may verify any of the information. I understand that I may be prosecuted under the law and have to pay back what I have received, if I have intentionally lied or withheld the truth. I may appeal any decision made by CSFP regarding my eligibility for the program.

Name of an Adult who can pick up my CSFP box _____

Signature of Applicant/Guardian: _____ Date: _____

Office use only: Eligible Ineligible

Category: INF CH PG PP SR Date of Certification: _____

Signature of Certifying Official: _____

Recertification (6 months)

Address and phone number verified? Yes NoIncome eligibility verified? Yes No

Signature of Certifying Official: _____ Date: _____