Commodity Supplemental Food Program (CSFP)
Application Form

W-1704
(Rev. 4/16)

Staff use only
Application date _____
End date _____

Please complete a separate application for each person who is applying.

Name: _____

Street address: _____ Apt. number: _____

City: _____ State: _____ Zip: _____

E-mail address: _____ Date of Birth: _____

Primary phone number: _____ Alternate phone number: _____

Total number of people in household: _____ Number of people age 60 or older in household: _____

Will someone else be picking up your CSFP food? ☐ Yes (if yes, fill out "Proxy Form") ☐ No

Please tell us about your race and ethnicity for data collection and reporting purposes. Providing this optional data will not affect your eligibility.

Ethnicity
☐ Hispanic or Latino/a
☐ Not Hispanic or Latino/a

Race (you may select more than one)
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ White

Please answer the following questions:	**YES**	**NO**
(1) Are you currently receiving food through CSFP?		
(2) Have you received food through CSFP in the past?		
(3) Is your family unit's gross income less than the amount listed below?		
(4) What is your family unit's gross monthly income: $		

***Copies of proof of income must be attached**. Examples of proof are: a social security award letter, pay stubs, business records.

Gross Income for All Members of the Family Unit 130% of Federal Poverty Income Guidelines		
Family Unit Size	**Monthly Income**	**Annual Income**
1	$1,287	$15,444
2	$1,736	$20,826
3	$2,184	$26,208
4	$2,633	$31,590
5	$3,081	$36,972
6	$3,530	$42,354

Applicant Rights and Responsibilities

I agree to:

- Provide proof of my income, address and identification.
- Give correct information about my current household and income.
- Tell my local agency if my address, income or household composition changes within 10 days of learning about the change

I understand that:

- The CSFP local agency will provide referrals to nutrition, health or assistance programs as appropriate.
- The CSFP local agency will make nutrition education available to all program participants.
- I will be terminated from the program if I participate in another CSFP program. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations will lead to a claim against you to recover the value of benefits, and may lead to disqualification from CSFP.
- If I do not pick up food for 2 months in a row, and I do not contact the local agency to let them know, I may be taken off the program.
- I may be disqualified if I sell CSFP foods or trade CSFP foods for non-food items
- I may be disqualified if I intentionally make false or misleading statements, orally or in writing.
- I may be disqualified if I intentionally withhold information pertaining to eligibility for CSFP.
- I may be disqualified if I physically abuse, or threaten to physically abuse, program staff.
- I have the right to appeal through the fair hearing process, any decision made by the local CSFP agency regarding denial, disqualification or termination from the program. A hearing request form should be mailed or faxed to:

  Department of Social Services
  Office of Legal Counsel, Regulations and Administrative Hearings
  55 Farmington Ave
  Hartford, CT 06105

  The fax number is (860) 424-5729. Hearing requests must be made in writing within 60 days of the date of the denial, disqualification or termination letter.

- 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 for 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 your decision by checking one of the following boxes: ☐ Yes ☐ No

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. I understand that I must notify the local CSFP agency of all changes of income, address or household composition with 10 days.

_____ _____

Signature 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.

STAFF USE ONLY

APPROVED _____ END DATE OF CERT. PERIOD_____

DATE PUT ON WAIT LIST _____ DENIED_____

LETTER OF FAIR HEARING GIVEN _____

PRINTED STAFF NAME _____

SIGNATURE _____

DATE _____

COMMENTS:

_____

_____

Commodity Supplemental Food Program (CSFP)
Recertification Form (due every 6 months)

W-1708
(Rev.4/16)

Staff use only
Renewal date_____
End date_____

Please complete a separate recertification form for each person enrolling in the program. Recertification forms must be received before the last day of the certification period.

Name: _____

Street address: _____ Apt. number: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Primary phone number: _____ Alternate phone number: _____

Total number of people in household: _____ Monthly household income: _____

Signature of Applicant: _____ Date: _____

Proxy Update
If there is no change, there is no need to complete this section. If you need to change your proxy (the person who picks up food for you) then you must complete the information below. The proxy must present appropriate identification at the time of food pick-up.

Individual or organization: _____

If organization, contact person: _____

Address: _____

City: _____ Zip Code: _____ Telephone Number: _____

If not returning in person, please mail this form to: _____
_____
_____

COMMODITY SUPPLEMENTAL FOOD PROGRAM
PROXY FORM

W-1707
(Rev 4-16)

Name of CSFP participant: _____

Telephone number: _____

I give permission to the person/organization designated below to pick up my food. I understand that by giving permission to the person/organization listed below, I accept all responsibility for their actions. I certify this party is at least 18 years of age. This authorization becomes effective when received by the CSFP local agency. I will notify the CSFP local agency promptly if I wish to change my proxy.

Alternate person/organization: _____

If an organization, contact person name: _____

Address: _____

Telephone number where proxy can be reached: _____

Email address for proxy: _____

I understand that any change in this designation must be requested in writing. I also understand that it is my responsibility to notify the designated person of dates and times of distribution. If CSFP is not picked up for two months in a row, I understand I may be taken off the program. Proof of identification must be presented when picking up commodities.

Participant signature: _____ Date: _____

CSFP staff signature: _____ Date: _____

A copy of this form must be placed in each participant's file.

Commodity Supplemental Food Program (CSFP)
Notice of Eligibility

W-1706
(Rev. 4-16)

Date: _____

Name: _____

Address: _____

_____

Dear applicant:

Your application for participation in the Commodity Supplemental Food Program (CSFP) has been approved, based on the age and income information you provided on the application form. The USDA requires participants to complete a review every six months. Your next eligibility review will be in _____.

We will not be able to provide food without identification so please bring some form of identification with you each time you pick up food. If you use a proxy, they must also provide identification.

☐ The distribution date, time and location of your food pick-up is noted below. Please be aware that this is not a first-come, first-serve program. A food box will be reserved for you at the site listed below. Please call the number listed below if you are unable to make your scheduled pick-up.

Date: _____
Time: _____
Location: _____
Telephone #: _____

☐ Unfortunately there are no CSFP slots available at this time. Your name will be placed on a waiting list. Those placed on the wait list will be notified if a slot becomes available.

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.

W-1709
(Rev. 4/16)

Commodity Supplemental Food Program (CSFP)
Notice of Denial or Termination

Name: _____ Date notice mailed: _____

You have been found to be ineligible to receive or continue to receive Commodity Supplemental Food Program benefits for the following reason(s):

_____ You are not a Connecticut resident.

_____ Your total household income exceeds the established guidelines.

_____ You do not meet the age requirements. In order to receive program benefits, you must be 60 years of age or older.

_____ You have not picked up commodities for two consecutive months.

_____ You voluntarily withdrew from the program.

_____ You have not completed your recertification form. Recertification must be completed every 6 months.

_____ Other: _____

If you feel you have received this notice in error, please contact the CSFP agency listed below.

CSFP Agency: _____ Telephone #: _____

Contact Person: _____

You have the right to a fair hearing regarding this decision. You may request a fair hearing by completing the enclosed hearing request form and mailing or faxing this notice of denial and the hearing request form to:

Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
55 Farmington Ave
Hartford, CT 06105
Fax Number: (860) 424-5729

You must request a fair hearing within 60 days of the date that this notice was mailed.

Commodity Supplemental Food Program (CSFP)
Hearing Request Form

W-1710
(Rev. 4/16)

Name: _____
Address: _____
_____

Please **use this form only if you want a hearing.** Remember, **before you ask for a hearing or at any time afterwards, you may call the local CSFP agency for help in solving the problem.**

I do not agree with the decision taken on my case. I am requesting a hearing because:

_____
_____
_____
_____

(Please use the back of this form if you need more room to write.)

My telephone number including the area code is: _____

Please check one:

☐ Under some programs, benefits may continue while the hearing decision is pending. If possible, I want my benefits to continue until the hearing decision is made. I understand that if the decision is not in my favor, I may have to pay back the benefits.

☐ I do not want my benefits continued while the Hearing Officer is deciding.

_____ _____
Signature Date

Mail or fax this completed request to:

Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
55 Farmington Avenue
Hartford, CT 06105
Fax Number: (860) 424-5729