DPHHS-FD-034
(Revised 11/19)

STATE OF MONTANA
Department of Public Health and Human Services

DATE:_____

ELDERLY COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) APPLICATION

Applicant: _____
Last Name First Name Middle Initial

Mailing Address: _____
Number Street City Zip County

Physical Address: _____
Number Street City Zip County

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Racial/Ethnic Data Collection Requirement:
Select ethnic category: ❑ Hispanic or Latino or ❑ Not Hispanic or Latino

Select race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American
(Select one or more) ❑ Native Hawaiian or other Pacific Islander ❑ White

Number of People in Household Including Applicant: _____

Household Members:	Age:	Date of Birth:	Relationship:

HOUSEHOLD INCOME:

SOURCE OF INCOME	AMOUNT RECEIVED	HOW OFTEN
Wages, Salary		
Social Security		
Supplemental Security Income (SSI)		
Public Assistance (TANF)		
Pension/Retirement (non-SS)		
Self-Employment		
Unemployment		
Other (Specify)		
Other (Specify)		
TOTAL HOUSEHOLD INCOME:		

(Total Must Not Exceed 130% of the current Federal Poverty Level Guidelines)

INCOME DIRECTIONS: Income should be as current as possible (previous month's). Indicate source, amount and how often received (weekly, monthly, bi-weekly, quarterly, annually) Income before deductions such as taxes and SS. MUST INCLUDE INCOME OF ALL HOUSEHOLD MEMBERS. If income inconsistently received, then project it on an annual basis. "Other, Specify" could be income from commissions, strike benefits, income from trusts, contributions from relatives, etc. ***SNAP BENEFITS (Food Stamps) do not count as income.***

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 aware I may not receive CSFP benefits at more than one CSFP site at the same time. I am also 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.

Continue on reverse side of this form.

Return to GVFB P.O. Box 1129 Bozeman, MT 59771

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Required Identification Verified: ☐ Driver's License ☐ Birth Certificate ☐ SSN (Don't record SSN#)

☐ Alternate ID (Specify):_____

The following individuals are authorized to act as my representative for CSFP:

Name	Relationship	Phone

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 APPLICANT _____ DATE _____

- *You will be notified of your eligibility, eligibility and placement on a waiting list, or ineligibility within 10 days of receipt of this correctly completed and signed application by the local CSFP agency.*
- *If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.*

NEW CERTIFICATION: ❑ **ELIGIBLE** ❑ **NOT ELIGIBLE**

Ineligibility reason: _____

- *You may appeal any decision made by the local agency regarding your denial or termination from the program. You have a right to a fair hearing.*

Certification for 1 year from _____ to_____

SIGNATURE OF CERTIFIER _____ TITLE _____ DATE _____

CIVIL RIGHTS 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.

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