

**Wichita and Affiliated Tribes
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

Name		Date of Birth	
Sex: _____ Male _____ Female		Age:	
Residence Address		City	Zip
Mailing Address		City	Zip
Home Phone #		County of Residence	
Phone number of a person who can take messages for me			
Ethnic and Racial Identities			
Choose one ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino		Choose one or more (regardless of ethnicity): _____ Asian _____ Black or African American _____ White _____ American Indian or Alaska Native _____ Native Hawaiian _____ or other Pacific Islander	
1. How many people live in your household?			
2. What is the total gross monthly income for your household?			
If I am unable to pick up food, I authorize the following person(s) to pick up my CSFP food for me:			
Name: _____ Phone # _____		Name: _____ Phone # _____	
<u><i>The following information must be read by or to the applicant before signature</i></u>			
<p>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 both CSFP and WIC benefits simultaneously, and 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 to 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.</p> <p>I authorize the release of information 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.)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
Signature of applicant:			
Date:		Witness, if applicant signs by Mark:	
TO BE COMPLETED BY CSFP STAFF			
Agency Number:		Type of ID:	Date Received
Agency Name:		County:	

**Wichita and Affiliated Tribes
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)
CSFP Participant Rights and Obligations**

(must be read by or to the applicant before signature):

- 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.
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits and may lead to disqualification from CSFP.
- I understand that the food packages provided by this program are solely intended for my consumption as a participant in the program. I understand that selling CSFP commodities or exchanging them for non-food items could result in my termination from the program. 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.
- I understand that I am only allowed to obtain one food package per month. I am aware that if I fail to obtain a food package during two consecutive months, my participation in the program can be terminated.
- I may appeal any decision made regarding termination from the program, and I may submit a request for a fair hearing to the Regional Food Bank of Oklahoma.
- Nutrition education will be made available to me and I am encouraged to participate in these services. The CSFP site will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
- I consent to the release of information regarding my application to and participation in the program to CSFP staff, to other CSFP agencies if I desire to transfer to a different site, and to the officials of the USDA, Oklahoma Department of Human Services, and the Regional Food Bank of Oklahoma.
- I understand that I must report changes in household income or composition within 10 days after the change.
- In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.
- 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
- 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.

Signature of applicant:	
Date:	Witness, if applicant signs by Mark:

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: [How to File a Complaint](#), 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.

**Wichita and Affiliated Tribes
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

TO BE COMPLETED BY CSFP STAFF
CSFP CERTIFICATION or DENIAL

Elderly Applicant

1. This applicant is 60 years old or older? (check date of birth) _____ YES _____ NO	
2. Household income is at or below 130% of poverty (see income chart) for size of household. _____ YES _____ NO	
_____ Denied. Question 1 or 2 answered NO. Issue Denial Notice _____ Certified. All questions answered YES. Issue Certification/ Wait List Notice	
Signature of Person Determining Eligibility	
Title	Date
CSFP Site Wichita Food Distribution Program	
DISTRIBUTION RECORD	
Please use this table to record dates the participant receives a food box. Please write "NO SHOW" if a participant fails to pick up their box. If they miss two months in a row they will be terminated from the program. A written notice must be provided within 15 days of the effective date. Participants will be verbally recertified after 1 year, as long as (i) the person's address and continued interest in receiving program benefits are verified; and (ii) the local agency has sufficient reason to believe that the person still meets the income eligibility standards. After two years, the participant must fill out a new application. You must notify a participant in writing that they are due for recertification at least 15 days before the end of their certification period. You must include a statement in the written notification that informs the applicant that program standards are applied without discrimination by race, color, national origin, age, sex, or disability.	
MONTHS CERTIFIED	ISSUANCE DATE
1 January	
2 February	
3 March	
4 April	
5 May	
6 June	
7 July	
8 August	
9 September	
10 October	
11 November	
12 December	
Verbal Recertify and continue on to the 2nd year on the back	

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**TO BE COMPLETED BY CSFP STAFF
CSFP VERBAL RECERTIFICATION
Elderly Applicant**

When verbally recertifying, ask the following questions to each participant and make any appropriate changes.

1. Is this still your correct address?	2. Is this still your correct phone number?
3. Is this still your correct monthly income?	4. Are the people you have listed as your Proxies, still correct?
Signature of Person Recertifying Participant	
Title	Date of Recertification
CSFP Site	

DISTRIBUTION RECORD

Please use this table to record dates the participant receives a food box.

If a participant fails to pick up a box for that month, please write "NO SHOW" in the signature line. If a participant misses two months in a row it will result in termination from the program. Participants must be notified by writing within 15 days of the effective date.

MONTHS CERTIFIED	ISSUANCE DATE	CLIENT SIGNATURE FOR FOOD
1 January		
2 February		
3 March		
4 April		
5 May		
6 June		
7 July		
8 August		
9 September		
10 October		
11 November		
12 December		