

For DS Use Only:

Date: _____

Client ID#: _____

DS: _____

APPLICATION FOR BENEFITS

TEFAP CSFP

APPLICANT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Number of People in the Household: _____

Gender (Optional): Male Female Undisclosed

Marital Status (Optional): Single Married Divorced Separated Widowed Undisclosed
 Common-Law

Address (No., Street): _____

City: _____ County: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Housing Type (Optional): Emergency Shelter/Mission/Transitional Evacuee Unhoused
 Own Home Private Rental Public (Social) housing
 With Family/Friends Youth Home/Shelter Undisclosed Other
 No Fixed Address/Undisclosed

Language (Optional): _____

Ethnicity (Required for CSFP): White/Anglo Black/African American Hispanic/Latino
 Pacific Islander Asian American Indian/Native American
 Alaska Native/Aleut/Eskimo Middle Eastern/North African Other

Self-identified as (Optional): Disability Undisclosed Veteran Mental Illness N/A
 Pregnant Postpartum Breastfeeding Other

AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

Proxy's Printed Name(s): _____

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. CSFP Clients: 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 under 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 decision by placing a checkmark in the appropriate box.)

Yes No

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

Applicant's Name (Please Print): _____

Applicant's Signature: _____ Date: _____

HOUSEHOLD MEMBER INFORMATION 1

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: Spouse Child Parent Sibling Grandparent Other Relative
 Boyfriend/Girlfriend Friend Undisclosed

Gender (Optional): Male Female Undisclosed

HOUSEHOLD MEMBER INFORMATION 2

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: Spouse Child Parent Sibling Grandparent Other Relative
 Boyfriend/Girlfriend Friend Undisclosed

Gender (Optional): Male Female Undisclosed

HOUSEHOLD MEMBER INFORMATION 3

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: Spouse Child Parent Sibling Grandparent Other Relative
 Boyfriend/Girlfriend Friend Undisclosed

Gender (Optional): Male Female Undisclosed

APPLICANT IS RECEIVING THE FOLLOWING

- Supplemental Nutrition Assistance Program (SNAP)
- Commodity Supplemental Food Program (CSFP)
- Other (Specify): _____

Household Members (continued)

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Gender (M-F-U)	Relationship

The USDA is an equal opportunity provider and employer. Auxiliary aids and services are available upon request to individuals with disabilities. TTY/TDD Services 7-1-1. Disponible en español linea en la oficina local.