



ALGER-MARQUETTE
COMMUNITY ACTION
 HELPING PEOPLE • CHANGING LIVES

1125 Commerce Drive, Marquette, MI. 49855 Phone 1-906-228-6522 or 1-800-562-9762

DATE _____

Commodity Supplemental Food Program (CSFP) Application

Eligibility for participation in CSFP is based upon an individual's age and income. Certification guidelines require:

1. All participants must meet income guidelines and provide proof of gross income.
 - Copy of bank statement, social security statement, or tax form
2. All participants must also meet age eligibility criteria:
 - Persons 60 years of age and over.

Household Information

# in Household	Source of Income	Annual Income	Monthly Income	Phone #	
Street Address		City		State	Zip
Mailing Address (If different)					
Family Type <input type="checkbox"/> Female Single Parent <input type="checkbox"/> Dual Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> One Adult <input type="checkbox"/> Two Adult <input type="checkbox"/> Other: _____			Email Address _____		

Head of Household

Name (Last, First, Middle Initial)	Date of Birth	Sex ____ M ____ F	
Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Multi-Racial			
Employment Hours/Week	Highest Grade Level Completed	High School Graduate ____ Y ____ N	College Graduate ____ Y ____ N
Residence ____ Own <input type="checkbox"/> Rent <input type="checkbox"/> Other	Marital Status (if separated, choose married until legally divorced) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Health Insurance ____ Yes <input type="checkbox"/> No
Disability <input type="checkbox"/> None <input type="checkbox"/> Alcohol/Drugs <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> Back/Appendages <input type="checkbox"/> Birth Defect <input type="checkbox"/> Brain Syndrome <input type="checkbox"/> Cancer <input type="checkbox"/> Circulatory/Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive <input type="checkbox"/> Emotional <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> M.S. <input type="checkbox"/> Mental <input type="checkbox"/> Neurological <input type="checkbox"/> Parkinson's <input type="checkbox"/> Sensory Loss <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple <input type="checkbox"/> Other _____			

Emergency Contact

Name	Mailing Address	Phone

ALL Other Household Members (Additional Forms Available for Additional Household Members)

Relation to Head of Household <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> In-law <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Grandchild			
Name (Last, First, Middle Initial)	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Do you receive WIC benefits? <input type="checkbox"/> Y <input type="checkbox"/> N
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Applicant's rights;

- The local agency will provide notification of a decision to deny or terminate CSFP benefits and of an individual's right to appeal this decision by requesting a fair hearing.
- The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants, and will encourage them to participate.
- The local agency will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
- If denied service, may appeal the denial in accordance with AMCAB Appeal Procedures.

Applicant's responsibilities;

- The 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, which may lead to disqualification from CSFP.
- The participant must report changes in household income or composition within 10 days after the change becomes known to the household.

Your signature gives CAAM permission to distribute your package to a local pantry should you be unable to pick-up at distribution.

In the operation of the CSFP program, no one will be discriminated against because of race, color, national origin, sex, age, or disability. Any person who believes that he or she has been discriminated against in any USDA related activity should write immediately to the Secretary of Agriculture, Washington, DC 20250.

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 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 AMCAB programs and 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 []

Applicant Signature

Date

Signature and title of person making final determination

Date

DO NOT WRITE BELOW THIS LINE

Certification Site: _____ <input type="checkbox"/> New Application <input type="checkbox"/> Recertification <input type="checkbox"/> Reactivation	Administrative Use Only Household # _____ <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Initials</th> <th style="width: 20%; text-align: center;">Date</th> </tr> </thead> <tbody> <tr> <td>Approved/Denied</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Entry</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Letter Sent</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Initials	Date	Approved/Denied	_____	_____	Entry	_____	_____	Letter Sent	_____	_____
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All Other Household Members

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