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.
   - Persons under 60 years of age with children from infancy to five years of age and are not on WIC.

Household Information

# in Household	Source of Income	Annual Income	Monthly Income	Phone #	
Street Address		City		State	Zip
Mailing Address (If different)					
Family ___Female Single Parent___Dual Parent Type ___Male Single Parent ___One Adult ___Two Adult ___Other:_____		Identification Driver's License No. _____ or Social Security No. _____			

Head of Household

Name (Last, First, Middle Initial)	Date of Birth	Sex _____ M _____F	Do you receive WIC benefits? ____Y ____N
Race ___White ___Asian ___Hispanic ___Black ___Native American ___Multi-Racial			Pregnant ___Y ___N
Employment Hours/Week	Highest Grade Level Completed	High School Graduate ___Y ___N	College Graduate ___Y ___N
Residence ___Own ___Rent ___Other	Marital Status (if separated, choose married until legally divorced) __Single __Married __Divorced __Widowed		Health Insurance ____Yes ____No

Disability

__None __Alcohol/Drugs __Alzheimer's/Dementia __Arthritis/Rheumatism __Back/Appendages
__Birth Defect __Brain Syndrome __Cancer __Circulatory/Hypertension __Diabetes
__Digestive __Emotional __Heart __Lungs __M.S.
__Mental __Neurological __Parkinson's __Sensory Loss __Stroke
__Multiple __Other_____

Emergency Contact

Name	Mailing Address	Phone

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

Relation to Head of Household
__Spouse __Parent __Grandparent __Sibling __In-law __Friend __Child __Foster Child __Niece/Nephew __Grandchild

Name (Last, First, Middle Initial)	Date of Birth	Sex ______ M ______F	Do you receive WIC benefits? ____Y ____N

Race ___White ___Asian ___Hispanic ___Black ___Native American ___Multi-Racial	Health Insurance ____Yes ____No

Employment Hours/Week	Highest Grade Level Completed	High School Graduate ___Y ___N	College Graduate ___Y ___N

Residence ___Own ___Rent ___Other	Marital Status (if separated, choose married until legally divorced) __Single __Married __Divorced __Widowed

Disability
__None __Alcohol/Drugs __Alzheimer's/Dementia __Arthritis/Rheumatism __Back/Appendages
__Birth Defect __Brain Syndrome __Cancer __Circulatory/Hypertension __Diabetes
__Digestive __Emotional __Heart __Lungs __M.S.
__Mental __Neurological __Parkinson's __Sensory Loss __Stroke
__Multiple __Other______________________________

Relation to Head of Household
__Spouse __Parent __Grandparent __Sibling __In-law __Friend __Child __Foster Child __Niece/Nephew __Grandchild

Name (Last, First, Middle Initial)	Date of Birth	Sex ______ M ______F	Do you receive WIC benefits? ____Y ____N

Race ___White ___Asian ___Hispanic ___Black ___Native American ___Multi-Racial	Health Insurance ____Yes ____No

Employment Hours/Week	Highest Grade Level Completed	High School Graduate ___Y ___N	College Graduate ___Y ___N

Residence ___Own ___Rent ___Other	Marital Status (if separated, choose married until legally divorced) __Single __Married __Divorced __Widowed

Disability
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__Birth Defect __Brain Syndrome __Cancer __Circulatory/Hypertension __Diabetes
__Digestive __Emotional __Heart __Lungs __M.S.
__Mental __Neurological __Parkinson's __Sensory Loss __Stroke
__Multiple __Other______________________________

Relation to Head of Household
__Spouse __Parent __Grandparent __Sibling __In-law __Friend __Child __Foster Child __Niece/Nephew __Grandchild

Name (Last, First, Middle Initial)	Date of Birth	Sex ______ M ______F	Do you receive WIC benefits? ____Y ____N

Race ___White ___Asian ___Hispanic ___Black ___Native American ___Multi-Racial	Health Insurance ____Yes ____No

Employment Hours/Week	Highest Grade Level Completed	High School Graduate ___Y ___N	College Graduate ___Y ___N

Residence ___Own ___Rent ___Other	Marital Status (if separated, choose married until legally divorced) __Single __Married __Divorced __Widowed

Disability
__None __Alcohol/Drugs __Alzheimer's/Dementia __Arthritis/Rheumatism __Back/Appendages
__Birth Defect __Brain Syndrome __Cancer __Circulatory/Hypertension __Diabetes
__Digestive __Emotional __Heart __Lungs __M.S.
__Mental __Neurological __Parkinson's __Sensory Loss __Stroke
__Multiple __Other______________________________

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 with in 10 days after the change becomes known to the household.

Your signature gives AMCAB 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 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 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	Administrative Use Only		
Site:_____	Household #_____		
____New Application ____Recertification		Initials	Date
____Reactivation	Approved/Denied	_____	_____
____Package Type	Entry	_____	_____
	Letter Sent	_____	_____