



## Commodity Supplemental Food Program (CSFP) Application Form

W-1704  
(Rev. 3/18)

Staff use only
Application date _____
End date _____

**(Please complete a separate application for each person who is applying)**

Name: \_\_\_\_\_

Street address: \_\_\_\_\_ Apt. number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Total number of people in household: \_\_\_\_\_ Number of people age 60 or older in household: \_\_\_\_\_

Will someone else be picking up your CSFP food?     Yes (if yes, fill out "Proxy Form")     No

Please tell us about your race and ethnicity for data collection and reporting purposes. Providing this optional data will not affect your eligibility.

Ethnicity

- Hispanic or Latino/a
- Not Hispanic or Latino/a

Race (you may select more than one)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian
- White

**Please answer the following questions:**

	YES	NO
(1) Are you currently receiving food through CSFP?		
(2) Have you received food through CSFP in the past?		
(3) Is your family unit's gross income less than the amount listed below?		
(4) What is your family unit's gross monthly income: \$		

<b>Gross Income for All Members of the Family Unit</b> 130% of Federal Poverty Income Guidelines		
<b>Family Unit Size</b>	<b>Monthly Income</b>	<b>Annual Income</b>
1	\$1,316	\$15,782
2	\$1,784	\$21,398
3	\$2,252	\$27,014
4	\$2,720	\$32,630
5	\$3,188	\$38,246
6	\$3,656	\$43,862

## Applicant Rights and Responsibilities

I agree to:

- Provide proof of my address and identification.
- Give correct information about my current household and income.
- Tell my local agency if my address, income or household composition changes within 10 days of learning about the change

I understand that:

- The CSFP local agency will provide referrals to nutrition, health or assistance programs as appropriate.
- The CSFP local agency will make nutrition education available to all program participants.
- I will be terminated from the program if I participate in another CSFP program. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations will lead to a claim against you to recover the value of benefits, and may lead to disqualification from CSFP.
- If I do not pick up food for 2 months in a row, and I do not contact the local agency to let them know, I may be taken off the program.
- I may be disqualified if I sell CSFP foods or trade CSFP foods for non-food items
- I may be disqualified if I intentionally make false or misleading statements, orally or in writing.
- I may be disqualified if I intentionally withhold information pertaining to eligibility for CSFP.
- I may be disqualified if I physically abuse, or threaten to physically abuse, program staff.
- I have the right to appeal through the fair hearing process, any decision made by the local CSFP agency regarding denial, disqualification or termination from the program. A hearing request form should be mailed or faxed to:

Department of Social Services  
Office of Legal Counsel, Regulations and Administrative Hearings  
55 Farmington Ave  
Hartford, CT 06105

The fax number is (860) 424-5729. Hearing requests must be made in writing within 60 days of the date of the denial, disqualification or termination letter.

- 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 for 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 your decision by checking one of the following boxes:  Yes  No

By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete. I understand that I must notify the local CSFP agency of all changes of income, address or household composition with 10 days.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Non-Discrimination 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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

*STAFF USE ONLY*

APPROVED \_\_\_\_\_ END DATE OF CERT. PERIOD \_\_\_\_\_

DATE PUT ON WAIT LIST \_\_\_\_\_ DENIED \_\_\_\_\_

LETTER OF FAIR HEARING GIVEN \_\_\_\_\_

PRINTED STAFF NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_