

Commodity Supplemental Food Program (CSFP) Application

Please Check One:

- Elder (60+ years)**
- Pregnant Woman** (Expected Delivery Date)_____
- Post-Partum Woman** (Actual Delivery Date)_____
- Child (0-6 years)**

Name, Last:_____ First:_____ MI:_____

Physical Address _____ Telephone number _____
(required)

City:_____ State: VT Zip Code:_____

Mailing Address (if different)_____

City:_____ State: VT Zip Code:_____

Senior Housing Site where you live (if applicable)_____

Name of Parent or Legal Guardian:_____

Monthly **Household** Income: \$_____ **Number** of Household Members_____

Age Verification

Please read the information below about the age requirements for CSFP participation.

1. **I will furnish a copy of evidence of age of self or child (birth certificate, driver's license etc) with this application . (do not send the original)**
2. If I don't have any documentation of proof of age, I will sign the statement below attesting to my date of birth.
3. My date of birth is _____

Signature:_____

Data in this section is a USDA statistical requirement for the program. Responses will not affect consideration of this application.

1. Are you Hispanic or Latino? ____ Yes ____ No
2. What is your race? (Select one or more)
 - ____ American Indian or Alaska Native
 - ____ Asian
 - ____ Black or African American
 - ____ Native Hawaiian or Other Pacific Islander
 - ____ White

Proxy Form

This form will allow you to designate a person to pick up your CSFP food. Proxies must present appropriate identification at the time of food pick up.

Participant or Parent/Caretakers Authorization of Proxy

I hereby give permission to the person/organization listed below to pick up/accept delivery of CSFP food for me when I am unable to do so. I understand in giving permission to the person/organization below, I accept all responsibility for their actions. This authorization becomes effective when received by the CSFP program. I agree to notify CSFP promptly if I decide to make any changes in (i.e. update, add or remove) my designated proxies.

If you are a resident of a senior housing site, you must indicate the name of the facility and the facility manager and/or their designee, so the facility may sign for the food delivery to your building on your behalf. An internal schedule has been arranged at your housing location for you to pick up your food. Please contact your facility manager for more information regarding the internal schedule.

If you are the parent or guardian of a minor applying for this program, you will automatically become one of the proxies. If you would like another individual or organization to pick up or accept delivery of your monthly food box, please complete the information below.

1. Individual or Organization:

If Organization, Contact Person Name: _____

Address: _____

City: _____ Zip Code: _____

Telephone #: _____

2. Individual or Organization:

If Organization, Contact Person Name: _____

Address: _____

City: _____ Zip Code: _____

Telephone #: _____

YOUR RIGHTS AND RESPONSIBILITIES IN THE VERMONT CSFP

I AGREE TO PROVIDE:

- Proof of my income, address, and identification if requested
- Correct information about my current household and income
- Any change in my address, telephone number, income, or household composition within ten (10) days after the change becomes known to the household.

I UNDERSTAND THAT:

- Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- CSFP will provide a box of supplemental foods each month at a predetermined delivery site
- CSFP will provide referrals to nutrition, health, or assistance programs as appropriate
- CSFP will provide written nutrition education to all program participants.
- If I do not pick up food three (3) months in a row, without telling staff, I will be taken off of the program.
- I will be dropped from this program if I participate in another CSFP or WIC program
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits, and may lead to disqualification from CSFP.
- I may appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.

CERTIFICATION

This application form 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 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

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

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 to the best of my knowledge.

Signature of Applicant/Guardian: _____ Date: _____

The CSFP staff at the Vermont Foodbank will review your application for eligibility. You will be notified by mail within ten (10) days if you are eligible, denied, or placed on a waiting list for entry into the program.

"In accordance with Federal Law and the U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through local the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Before mailing have you:

- Completed all the sections of the application?
- Included a copy of proof of age?(birth certificate, license, passport)*
- Signed & dated the application on page 3?

* If you do not have proof of age, you must sign the age verification on page 3.

Questions? Call Wayne Holt at the Vermont Food Bank

Call 1-800-214-4648 or 1-802-477-4120

Fax: 1-802-476-3326

www.vtfoodbank.org

-----**FOLD**-----

FROM:

POSTAGE REQUIRED

Mail or fax completed form to:
The Vermont Foodbank
Commodity Supplemental Food Program
33 Parker Rd.
Barre, Vermont 05641