

Ohio Department of Job and Family Services
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) CERTIFICATION

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| Return completed application to |
| West Ohio Food Bank |
| Street Address or Box Number |
| 1380 E. Kibby St. |
| City, State Zip Code |
| Lima, OH 45804 |

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| Local Agency |
| West Ohio Food Bank |
| Distribution Site |

APPLICANT INFORMATION PLEASE PRINT

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|---|----------------------------|--------------------|--------------------------------------|----------------------|---|
| Date | Applicant Last Name | First Name | Middle Initial | Date of Birth | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Address (Street Address or Box Number) | | City, State | County | | Zip Code |
| Mailing Address (Street Address or Box Number) | | City, State | County | | Zip Code |
| Primary Telephone (include area code) | | | Number of People in Household | | |

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| Income \$ | How often is the income received? <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly <input type="checkbox"/> Monthly |
| Alternate Telephone (include area code) | Ethnicity - Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White | |
| Handicap <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Authorized Representative Information I authorize the following individual to act on my behalf in matters related to CSFP.

| | | |
|----------------------------------|---|----------------------------------|
| Authorized Representative | Name | Phone (include area code) |
| | Address (Street Address or Box Number) | Zip Code |

Proxy Information In the event that I am unable to pick up my commodity food box from the distribution site, I authorize the following individual to pick up my commodity food box and sign the receipt log for me. I understand that I accept full responsibility for the actions of my proxy and will inform him/her of the proper procedure for commodity pick up.

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| Proxy | Proxy #1 Name | Phone (include area code) |
| | Proxy #2 Name | Phone (include area code) |

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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: 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 file a Program Discrimination Complaint as a USDA Customer | Office of the Assistant Secretary for Civil Rights 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.

This institution is an equal opportunity provider.

APPLICANT AGREEMENT

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. This application is being completed in connection with the receipt of Federal assistance.
3. Program officials may verify information on this form.
4. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
5. I may appeal any decision by the local agency regarding my eligibility for the CSFP. A request for a fair hearing can be submitted to the local agency.
6. The local agency will make health service and nutrition education materials available to me and I am encouraged to participate in these services.
7. I understand that participating in more than one CSFP program at the same time is not allowed and will result in being removed from the program.
8. **I understand that I may be dropped from the program if I fail to pick up my commodity food box two (2) months in a row with no communication.**
9. I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.
10. I understand CSFP is a supplemental rather than a total food program.
11. I consent to the release of information by program staff to another CSFP agency to which I may transfer, and to officials of USDA and the Ohio Department of Job & Family Services.
12. I understand that I must report changes in household income, or changes in the composition of the household, within ten days after the change becomes known to the household.
13. I understand that physical abuse, or the threat of physical abuse, of CSFP staff is a program violation. My participation in CSFP may be terminated for this and for other program violations.
14. I have been advised on my rights and responsibilities under the CSFP.

Please read the following statement carefully, then sign the form and write in today's date.

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 responsibilities under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

Your response to the following question does not affect consideration of this application. 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

Applicant Signature

Date

TO BE COMPLETED BY PROGRAM STAFF

| Date of Initial Application Received | Eligibility | Determination | Date Certified/Denied |
|--------------------------------------|--|---|--|
| | Income <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Eligible | Certification Period: From _____ to _____ |
| | Residency <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Not Eligible | |
| | Age <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Eligible and On Waiting List | |

I hereby certify that this assessment was made in compliance with federal and state program guidelines. All eligibility criteria were applied as defined by the ODJFS.

| Signature | Title | Date |
|-----------|-------|------|
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| Date Recertification Due By: | In order to continue receiving CSFP benefits, you will need to complete the recertification process. |
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Notes: