MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMODITY SUPPLEMENTAL FOOD PROGRAM

PARTICIPANT APPLICATION

Is the applicant or any qualifying household member participating in CSFP at another site? ☐ YES ☐ NO

Improper use or receipt of CSFP benefits because of dual participation or other **program violations may lead to a claim against the individual** to recover the value of the benefits, and may lead to disqualification from CSFP.

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

Name	Address	
City/State	Zip Code	Telephone Number
Date of Birth	Total Number in Household	

Names of Other Qualifying Household Members	AGE	DATE OF BIRTH	

Indicate the source and amount of current (last month's) income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income would include commissions, strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average monthly income during the previous 12 months.

Type of Income	Amount	How Often Received
TOTAL HOUSEHOLD INCOME		

Racial/Ethnic (Optional)
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
Are you of Hispanic or Latino origin? ☐ YES ☐ NO					

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, 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.
This institution is an equal opportunity provider.

NAME OF APPLICANT

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

- ✓ Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the Program.
- ✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- ✓ You must report changes in household income or composition within 10 days after the change becomes known to the household.

If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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 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 [ ]

Signature ►	DATE
Signature (Update information, sign and date to update when coming off waiting list) ►	DATE

* **FOR CERTIFYING AGENCY USE ONLY** * * * * * * * * * * * * * * * * * * *

☐ IDENTITY/ELIGIBILITY/AGE Describe proof:	☐ RESIDENCY VERIFIED ☐ H&SS HANDOUT GIVEN	APPLICANT ELIGIBLE? ☐Y ☐N	CASELOAD AVAILABLE? ☐Y ☐N	DATE WRITTEN NOTICE GIVEN:
Signature of Certifying Official		Date Certified	Date Certified	Certification Period 1st Month: Last Month: