Georgia Department of Human Services
COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

County Name: _____ Food Bank: ACFB LDA: Senior Community Outreach

Applicant Information (Please Print Clearly)

Applicant Name:	Date of Birth:	Age:	Sex:	Application Date:

Street Address:	City:	State:	Zip Code:	Telephone:

Racial/Ethnic Data

(Data will not affect consideration of application for assistance. This information is requested solely to ensure compliance with Federal Civil Rights laws.)

Ethnic Category
Are you Hispanic or Latino? (Select only one)
❑ Yes ❑ No

Racial Category (Select one or more)
❑ Asian
❑ Asian and White
❑ White
❑ Multiple Races Not Shown
❑ American Indian or Alaska Native
❑ Native Hawaiian or Other Pacific
❑ Black or African American
❑ American Indian or Alaska Native and White
❑ Black or African American and White
❑ American Indian or Alaska Native and Islander and Black or African American

"This application is being made 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 responsibilities 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. "

❑ Yes ❑ No

I certify that I have not applied for or received benefits from any other Commodity Supplemental Food Program (CSFP) site in the month of application; nor will I apply for and receive CSFP or WIC benefits in subsequent months at the same time as I receive benefits under this application, if I am certified.

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.

Signature of Applicant: _____ **Date:** _____

Certification Information (To be completed by CSFP Site Staff Only.)

Initial Certification	**Action Date:**	**Eligibility Notification Letter Given/Sent:** ❑ Yes ❑ No
Gross Household Income: $ _____ ❑ Monthly ❑ Yearly		**Date Eligibility Notification Letter Given/Sent:**

Other Household Members (Check if included for CSFP) **Total Number of CSFP Household Members** _____

Name	DOB	✓	Name	DOB	✓
Name	DOB	✓	Name	DOB	✓
Name	DOB	✓	Name	DOB	✓
Name	DOB	✓	Name	DOB	✓

Status: ❑ **Eligible (Active)** ❑ **Eligible (Waiting List)** ❑ **Denied** **Reason for Denial:**

Eligibility Verification (Document the verification used for each eligibility criteria listed below):

Eligibility Criteria	**Verification Source**
Age	Verification Type/Date on Documentation:
Income Eligibility Categorical Income Eligibility	Verification Type/Gross Amount/Date on Documentation: Current Approval/Continued Eligibility Notification: ❑FS ❑ TANF ❑Medicaid ❑ SSI Renewal Period _____ to _____
Residence	Verification Type/Date on Documentation:

Nutrition Education: Nutrition Education discussed and/or materials provided? ❑Yes ❑ No

I hereby certify that this assessment was made on the basis of information contained within agency files. All eligibility criteria were applied as defined by the Georgia Department of Human Services.

Agency Certification Staff Printed Name/Signature: _____ **Title:** _____

Georgia Department of Human Services
COMMODITY SUPPLEMENTAL FOOD PROGRAM

PARTICIPANT AGREEMENT

- I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
- I understand program benefits are provided in connection with the receipt of Federal assistance. Program officials may verify information I have provided to determine my eligibility.
- I consent to the release of information to CSFP Program staff and other individuals responsible for the operation of the Program for eligibility determination and health related activities which are a part of the program.
- I understand my information will be used to comply with federal regulations (7CFR 247.19, 7CFR 247.20) which stipulates that participants may not receive both CSFP and WIC benefits simultaneously, and may not receive CSFP benefits at more than one CSFP site at the same time. Other identifying information will be used to detect and prevent dual participation.
- I understand that participating in the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP) at the same time is not allowed and will result in being removed from at least one program and/or disqualification.
- I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
- I understand that I may appeal any decision made regarding my eligibility for the program. A request for a fair hearing can be submitted to the State or Local Agency.
- I understand that health services information and nutrition education information will be made available to me and I am encouraged to participate in these referred services.
- I understand that if determined eligible for the Program, I will pick up Supplemental Foods as directed. I understand that failure to pick up food as directed may result in me being dropped from the Program.
- I understand that the foods provided by the program are intended for the participant for whom they are prescribed.
- I understand CSFP is a supplemental rather than total food program.
- I understand that I must report changes in household composition and/or income within 10 days of when it is known to have occurred.

Requesting a Fair Hearing

If I am dissatisfied with any decision made regarding my eligibility, the following procedures may be followed:

- I understand that I may request to have my case reviewed by staff of the local agency or state agency for accuracy.
- I understand that I may request a Fair Hearing orally or in writing by contacting the Georgia Department of Human Services, Two Peachtree Street, Atlanta, GA, 30303. My request for a hearing must be made within 60 days of the date of the notice informing me of denial or termination from the CSFP program.
- I understand that a hearing shall be scheduled within 45 days of the date of my request. I will be provided at least 10 days advance notice of the hearing date, location and time.
- I understand that I may represent myself or select a representative to speak on my behalf at the hearing. If I or my representative cannot appear at the scheduled time and place, I may request the hearing officer to reschedule the hearing. I may request the hearing be rescheduled only one time.

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.

Applicant/Participant Signature	Agreement Date	CSFP Staff Person
		CSFP Staff Phone #

Georgia Department of Human Services
COMMODITY SUPPLEMENTAL FOOD PROGRAM

Authorized Representative (Proxy) Designation Form

Participant Name:				
Address:				
Phone #:				
Representative Name:			Rep. Phone Number	
Period Authorized:	Beginning Date:		Ending Date:	

My signature below acknowledges that I have authorized the above named individual to serve as my Authorized Representative (Proxy) for the Commodity Supplemental Food Program. I hereby give permission for my authorized Representative to complete certification activity and receive CSFP commodities on my behalf.

_____ _____

Participant Signature Date

My signature below acknowledges that I have agreed to serve as the Authorized Representative (Proxy) in the Commodity Supplemental Food Program for the above named CSFP participant. I understand that commodities received under this program are intended solely for the use of the participant and I may be held liable for the loss of commodities received under this program or for providing false or misleading information on behalf of the participant in order to obtain program benefits.

_____ _____

Representative Signature Date

Revocation of Authorized Representative (Proxy)

☐

My signature below acknowledges that I have revoked permission for the above mentioned (Representative Name) person as my authorized representative effectively immediately.

_____ _____ _____

Participant Signature Date Revocation Effective Date

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.