DPHHS-FD-034
(Revised 01/16)

STATE OF MONTANA
Department of Public Health and Human Services

DATE:_____

ELDERLY CSFP APPLICATION

Applicant _____
(Last Name) (First Name) (Middle Initial)

Address_____
(Number) (Street) (City) (Zip) (County)

Contact Phone:_____ Email:_____

☐ **ID VERIFIED &** **TYPE OF ID:** ☐ **Drivers License** ☐ **Birth Certificate** ☐ **SSN** (Don't record SSN#)

☐ **Alternate ID (Specify)**:_____

Other Program Participation that meets CSFP eligibility criteria? ☐ Yes - Program:_____ ☐ No

Number of People in Household Including Applicant:_____

Household Members:	Age:	Date of Birth:	Relationship:

RACIAL/ETHNIC DATA COLLECTION REQUIREMENT:

What is your ethnic category?: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your race? (Select one or more): ☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

HOUSEHOLD INCOME: (Total Must Not Exceed 130% of the Current Federal Poverty Level Guidelines)

SOURCE OF INCOME	AMOUNT RECEIVED	HOW OFTEN RECEIVED
Wages, Salary		
Social Security		
Public Assistance (Welfare)		
Pension/Retirement (non-SS)		
Self-Employment		
Unemployment		
Other (Specify)		
Other (Specify)		
TOTAL HOUSEHOLD INCOME		

INCOME COMPLETION DIRECTIONS: Income should be as current as possible (previous month's)
Indicate source, amount and how often received (weekly, monthly, bi-weekly, quarterly, annually) Income before deductions such as taxes and SS. MUST INCLUDE INCOME OF ALL HOUSEHOLD MEMBERS. If income inconsistently received then project it on an annual basis. "Other, Specify" could be income from commissions, strike benefits, income from trusts, contributions from relatives, etc.
SNAP BENEFITS (Food Stamps) do not count as income.

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 aware I may not receive CSFP benefits at more than one CSFP site at the same time. I am also 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.

Please see reverse side of this form.

State of Montana CSFP Elderly Application - page 2

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 OF APPLICANT) (DATE)

- *You will be notified of your eligibility, eligibility and placement on a waiting list, or ineligibility within 10 days of receipt of this correctly completed and signed application by the local CSFP agency.*
- *You may appeal any decision made by the local agency regarding your denial or termination from the program. You have a right to a fair hearing.*
- *If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.*

THE FOLLOWING AUTHORIZED INDIVIDUALS MAY TO ACT AS MY REPRESENTATIVE FOR CSFP:

NAME_____ RELATIONSHIP TO APPLICANT_____

NAME_____ RELATIONSHIP TO APPLICANT_____

IF INELEGIBLE PLEASE STATE REASON:_____

_____

NEW CERTIFICATION: ID VERIFIED:_____ **ELIGIBLE**_____ **NOT ELIGIBLE**_____

CERTIFICATION DATE FROM_____TO_____

TITLE OF CERTIFIER_____SIGNATURE_____ DATE_____

2ND CERTIFICATION : ID VERIFIED:_____ **ELIGIBLE**_____ **NOT ELIGIBLE**_____

CERTIFICATION DATE FROM_____TO_____

TITLE OF CERTIFIER_____SIGNATURE_____ DATE_____

Every Six Month Review Requirement: CLIENT CONTACT BY PHONE_____ IN PERSON_____

CLIENT WISHES TO REMAIN ON CSFP FOR A CONSECUTIVE SIX MONTHS? _____

NEW ADDRESS (IF CHANGED)_____

CIVIL RIGHTS 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, 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.