Ohio Department of Job & Family Services (ODJFS)

Commodity Supplemental Food Program (CSFP) Certification Form

Local Agency ______________________________ Distribution Site______________________________

APPLICANT INFORMATION			**PLEASE PRINT**
Date:			
Applicant Name:	Last	First	Middle Initial
Address:	Street Address or Box Number	City, State	County / Zip Code
Telephone:	( )	**Household Size**	**Income**
Date of Birth:		**Sex:** ☐Male ☐ Female	**Handicap:** ☐Yes ☐No
Ethnicity Are you Hispanic or Latino? ☐ Yes ☐No	**Race**	☐American Indian or Alaskan Native ☐Hawaiian or Other Pacific Islander	☐ Black or African American ☐Asian ☐ White
Authorized Representative:	Name	Address	Phone ( )
Proxy Information:	In the event that I am unable to pick up my commodity food box from the distribution, I authorize the following 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.		
Proxy:	Name	Phone ( )	
	Name	Phone ( )	

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 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 [ ]

Signature: ____ **Date:**

Are You Currently Receiving Food Stamp Assistance? If Yes, How Much? ☐Yes ☐ No $_________

If "No", do you want information about Food Stamp Assistance in addition to CSFP? ☐Yes ☐ No

TO BE COMPLETED BY PROGRAM STAFF			
Date of application (this certification):		**Date certified/denied:**	
Category:	☐ Child	☐ Elderly	
Eligibility Verification:	☐ Categorical	☐ Residency	
Determination:	☐ Eligible	☐Not Eligible	☐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:**

RECERTIFICATION			
Date of recertification:			
Eligibility Verification:	☐Categorical	☐Residency	
Determination:	☐Continue/ 6 months	☐Terminate N/I	☐Waiting List
Changes:			

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:**

APPLICANT AGREEMENT

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. Program benefits are provided 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 the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP) at the same time or participating in more than one WIC or CSFP program at the same time is not allowed and will result in being removed from at least one program.
8. I have been advised on my rights and obligations under the CSFP.
9. If participating in CSFP, I will pick up food as directed. **Failure to pick up food as directed may result in being dropped from the program**.
10. I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.
11. I understand CSFP is a supplemental rather than a total food program.
12. I consent to the release of information by program staff to WIC agency, another CSFP agency to which I may transfer, and to officials of USDA, Ohio Department of Health and the Ohio Department of Job & Family Services.

REQUESTING A FAIR HEARING

If I am dissatisfied with any decisions made regarding the eligibility or receipt of benefits, the following procedure may be followed:

13. I may talk with the CSFP workers at this distribution site, contact the local CSFP program director, or the CSFP State Program Director at the Ohio Department of Job & Family Services to have my case reviewed.
14. If I am not satisfied with the explanation of the workers or the local program director, I may request a fair hearing by mail, verbally, or present a written request in person to the local program director. My request should be made within 60 calendar days from the date the local agency mailed or gave me notice of denial or termination of benefits.
15. I will be contacted by the State Program Director or his/her designated representative within a week after my request is received. At this time a date will be set for the hearing. I will be notified at least 10 calendar days before the hearing. The hearing will be held within 21 calendar days of receipt of the request for a fair hearing.
16. I may present my position personally or select a representative to do so. If my representative or I cannot appear at the scheduled time and place, I may request the hearing officer to change it. I will be provided one opportunity to reschedule the hearing date upon written request submitted to the CSFP Office at the Ohio Department of Job & Family Services.
17. If my representative or I do not appear for the hearing or if I request the hearing to be canceled, it will be canceled.
18. The local program director and I will be sent a written decision concerning the hearing within 45 calendar days after the hearing was requested.
19. The CSFP must follow the decision. I must follow the decision also.
20. If I do not agree with the decision made at the local hearing, I may ask for an appeal by contacting the state agency as follows: CSFP-Office of Family Stability, Ohio Department of Job & Family Services, 145 S. Front St., Columbus, OH 43215-4156. If I desire an appeal, a request for a rehearing must be filed within 10 calendar days after the receipt of the fair hearing decision.
21. The detailed Fair Hearing Procedures are on file with the local agency CSFP director. A copy is available upon request.

In accordance with federal law and 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 Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington DC 20250-9410 or call 202-720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.