



**COMMODITY SUPPLEMENTAL FOOD PROGRAM
ELIGIBILITY REQUIREMENT**

All applicants must provide **copies** of the following items. Acceptable examples of each are provided.

1. PROOF OF AGE – Must be 60 or older even if totally or partially disabled.

Examples include a copy of one of the following:

- Driver’s License
- State ID Card
- Birth Certificate
- Other legal document that lists your date of birth

2. PROOF OF ADDRESS – Must be resident of Ohio and live in a participating county.

Examples include a copy of any of the following that list your current address dated within the past 30-60 days:

- Rent/lease agreement or
- Bank Statement or Insurance (car, health) or
- Recent Utility Bill (electric, cable, water, phone, etc.) or
- Other legal document that lists your current address.

Income Eligibility Guideline

(Guidelines are established by U.S. Dept. of Agriculture based on 130% of current Federal Poverty Guidelines)

Household Size	Annual	Monthly	Household Size	Annual	Monthly
1	\$19,578	\$1,632	5	\$47,554	\$3,963
2	\$26,572	\$2,215	6	\$54,548	\$4,546
3	\$33,566	\$2,798	7	\$61,542	\$5,129
4	\$40,560	\$3,380	8	\$68,536	\$5,712

Please mail completed application to: Southeast Ohio Foodbank – CSFP
1005 C.I.C. Drive
Logan, OH 43138

Or you may fax information to: 1-740-385-0866; email to abby.poling@hapcap.org

Please make sure you sign your application, all copies are included, and all information is completed. Please call 740-385-6813 EXT. 2221 with any questions.

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

Return completed application to Southeast Ohio Foodbank
Street Address or Box Number 1005 CIC Drive
City, State Zip Code Logan, OH 43138

Local Agency Southeast Ohio Foodbank
Distribution Site

APPLICANT INFORMATION PLEASE PRINT

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		
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.

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf> from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
 - fax:** (833) 256-1665 or (202) 690-7442; or
 - 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
Income YES NO
Residency YES NO
Age YES NO

Determination
 Eligible
 Not Eligible
 Eligible and On Waiting List

Date Certified/Denied

Certification Period:
From to

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

Date Recertification Due By:

In order to continue receiving CSFP benefits, you will need to complete the recertification process.

Notes:

Client ID # _____

Program Year: _____

CSBG INTAKE

SS#: _____ Last Name: _____ First Name: _____

DOB: _____ Address: _____

City: _____ Zip: _____ County: _____

Phone #: _____ Message Phone #: _____ Whose Phone: _____

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity: <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Native Alaskan <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Multi-Race (any 2 or more above)
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Agency Site: _____	Client E-mail: _____
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Education: <input type="checkbox"/> A. 0-8 <input type="checkbox"/> B. 9-12 (Non-Grad) <input type="checkbox"/> C. HS Grad/GED <input type="checkbox"/> D. 12+ <input type="checkbox"/> E. 2-4 yr. Grad College	Food Stamps: <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance: <input type="checkbox"/> A. Medicaid <input type="checkbox"/> D. Self-Ins. <input type="checkbox"/> B. Medicare <input type="checkbox"/> E. None <input type="checkbox"/> C. Private <input type="checkbox"/> F. Unknown	Farmer: <input type="checkbox"/> A. Farmer <input type="checkbox"/> B. Migrant <input type="checkbox"/> C. Seasonal
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Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	# In HH	Family Type: <input type="checkbox"/> F. Single Par/Female <input type="checkbox"/> Single <input type="checkbox"/> M. Single Par/Male <input type="checkbox"/> Couple <input type="checkbox"/> Two Parent <input type="checkbox"/> Other	Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other	Income Eligibility Period: <input type="checkbox"/> A. Weekly <input type="checkbox"/> D. Annually <input type="checkbox"/> B. Bi-Weekly <input type="checkbox"/> E. 13 Weeks <input type="checkbox"/> C. Monthly <input type="checkbox"/> F. 3 Months <input type="checkbox"/> G. 6 Months
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Source of Income: <input type="checkbox"/> A. Employment <input type="checkbox"/> C. Social Security <input type="checkbox"/> E. GA <input type="checkbox"/> G. Pension <input type="checkbox"/> I. Other <input type="checkbox"/> B. Unemployment <input type="checkbox"/> D. TANF <input type="checkbox"/> F. SSI/SSD <input type="checkbox"/> H. No Income <input type="checkbox"/> J. Zero Income <input type="checkbox"/> K. Refused - Only used for programs that do NOT require income verification	Income Amount:
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Other Household Members						
Use codes from above ONLY for information listed below						
SS#						
Last Name						
First Name						
Date of Birth						
Male/Female (M, F)						
Disabled (Y, N)						
Ethnicity (B, A, NHPI, NA, HL, W, O, MR)						
Education (A, B, C, D, E)						
Veteran (Y, N)						
Health Insurance (A, B, C, D,E, F)						
Income Period: (A, B, C, D, E, F, G)						
Source (A, B, C, D, E, F, G, H, I,J,K)						
Income Amount						

Code#:																	Initials	Date	
# of Units:																		Intake:	
Date of Service:																		Data Entry	

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

Comments: _____

Tear off this section and give it to the applicant

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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.
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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.

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:

1. 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.
2. 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.
3. 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.
4. 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.
5. If I do not appear for the hearing or if my authorized representative or I request the hearing to be canceled, it will be canceled.
6. The local program director and I will be sent a written decision concerning the hearing within 45 calendar days after the hearing was requested.
7. The CSFP local agency must follow the decision. I must follow the decision also.
8. 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 Assistance, Ohio Department of Job & Family Services, 4020 East 5th Ave. PO Box 183204, Columbus, OH 43218-3204. 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.
9. The detailed Fair Hearing Procedures are on file with the local agency CSFP director. A copy is available upon request.

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