



**COMMODITY SUPPLEMENTAL FOOD PROGRAM
ELIGIBILITY REQUIREMENT**

Please complete all sections of this application.

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
- 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:

- Driver’s License/State ID
- Recent Utility Bill (electric, cable, water, phone, etc.)
- Other legal document that lists your current address.

Income Eligibility Guideline

(Guidelines are established by U.S. Dept. of Agriculture based on 150% of current Federal Poverty Guidelines)

| Household Size | Annual | Monthly | Household Size | Annual | Monthly |
|----------------|----------|---------|----------------|----------|---------|
| 1 | \$23,940 | \$1,995 | 5 | \$58,020 | \$4,835 |
| 2 | \$32,460 | \$2,705 | 6 | \$66,540 | \$5,545 |
| 3 | \$40,980 | \$3,415 | 7 | \$75,060 | \$6,255 |
| 4 | \$49,500 | \$4,125 | 8 | \$83,580 | \$6,965 |

**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 foodbankhelp@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, audiotape, 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: [AD-3027 Form](#) 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:

1. **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **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 | Determination | Date Certified/Denied |
|--------------------------------------|--|---|--|
| | Income <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Eligible | Certification Period: From 2026 to 2027 |
| | Residency <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Not Eligible | |
| | Age <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Eligible and On 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 CSFP/AR Manager | Date |
|-----------|--------------------------|------|

| | |
|------------------------------|--|
| Date Recertification Due By: | In order to continue receiving CSFP benefits, you will need to complete the recertification process. |
|------------------------------|--|

Notes:

Tear off this section and give it to the applicant

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.

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, 30 East Broad St. PO Box 183204, Columbus, OH 43215. 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.

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: [AD-3027 Form](#) 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: 1. **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or 3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

