Division of Women, Infants & Children
Indiana Department of Health

Commodity Supplemental Food Program (CSFP)
Participant Application

Form CSFP 0003
Effective 01/27/2023

Local Agency	**Distribution Site**
Porter County Aging & Community Services	PCACS

Household Information (PLEASE PRINT) *To be completed by Applicant, Household Member, Authorized Representative or Agency that is determining eligibility.*

Name of Applicant (Last, First, Middle Initial)		Date of Birth
Address (Street, City, State, ZIP Code)	**Area Code and Telephone No.**	**Gender** ☐M ☐F ☐NB

Have you ever received food from the Commodity Supplemental Food Program? ☐ Yes ☐ No

If yes, where? _____

Date applicant last received food from the CSFP:

Income Description	**Amount**	**Frequency**

Total number of household members	Total gross income (before deductions) of all household members **$** ☐ Weekly ☐ Monthly ☐ Yearly	**Note:** SNAP benefits do not count as income.

CSFP Income Guidelines (130% of poverty)

I hereby certify that my household income is at or below the following guidelines: ***Yes [ ]*** ***No [ ]***

Household Size	**Annual**	**Monthly**	**Household Size**	**Annual**	**Monthly**
1	$ 18,954	$ 1,580	5	$ 45,682	$ 3,807
2	$ 25,636	$ 2,137	6	$ 52,364	$ 4,364
3	$ 32,318	$ 2,694	7	$ 59,046	$ 4,921
4	$ 39,000	$ 3,250	8	$ 65,728	$ 5,478
	For each additional household member, add			$ 6,682	$ 557

To be completed by program staff

Eligibility	**Category**	**Determination**	Date Determination Notice Sent:
Income ☐ Yes ☐ No	☐ Elderly ☐ Not categorically eligible	☐ Eligible ☐ Not Eligible	Determination Date: Date of Initial Visit:
Residence ☐ Yes ☐ No		☐ Eligible–On Waiting List	Certification Period _____ - _____

Signature-Individual Making Determination	Title-Individual Making Determination
Jeraski	Deputy Director

Participant Acknowledgement

If placed on the program, I will pick up food as directed. Failure to pick up food as directed may result in being dropped from the program.

I understand that if I choose to send an alternate (proxy) to pick up my food, I must have a completed Proxy Form on file designating that person.

I understand that the food provided by this program is intended for the participant for whom it is prescribed.

Fair Hearing

I may appeal any adverse decision made regarding my eligibility for the Program. I or my caregiver may request a fair hearing by making a verbal or written request to a State or Local Agency official within 60 days of the notification date of an adverse action.

MUST BE COMPLETED. If applicant refuses, fill in this section based on intake person's visual determination.

Race: Black or African American □ Black or African American and White □ White □ Asian and White □

American Indian or Alaska Native □ American Indian or Alaska Native and Black or African American □

Native Hawaiian or Other Pacific Islander □ American Indian or Alaska Native and White □ Asian □

Ethnicity: Hispanic or Latino □ Not Hispanic or Latino □

Certification (MUST BE READ TO APPLICANT BEFORE SIGNING): 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 obligations under the program, including the right to appeal any decision made by the local agency regarding my denial or termination from the Program. I understand that the local agency will make nutrition education available to me and I am encouraged to participate. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorized 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 – Applicant	Date	Name of Proxy – Optional *(print)*

STAFF CERTIFICATION: I certify I have read this page to the applicant and all items are completed.

Staff Printed Name	Date	Staff Signature
Judy Peracki		

NONDISCRIMINATION:

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: 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

(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: (833) 256-1665 or (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Indiana Department of Health

Division of Women, Infants & Children

Form CSFP0005
March 18, 2021

Commodity Supplemental Food Program (CSFP)

Receipt of USDA Products

PROXY STATEMENT

This proxy is for the individual recipient who is unable to pick up a CSFP package at the designated location and time. Local agency or certification/distribution site staff or volunteer completes this form and verifies identity of applicant/participant and proxy.

CSFP Applicant / Participant Information(PLEASE PRINT)

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

DAYTIME PHONE NUMBER: _____

Proxy Information (PLEASE PRINT)

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

DAYTIME PHONE NUMBER: _____

☐ One-Time Only ☐ Permanent

Completed and Verified By: JPenacki _____ Date: _____

LA/Site Personnel Signature

Title of Verifier: Deputy Director

This institution is an equal opportunity provider.