



COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

Please complete one application for each person you are enrolling on the program.

Case No: _____

Site: _____

Date: ____/____/____

Applicant Information

First Name

Last Name

Middle Initial

____/____/____
Date of Birth

Verified By

Street Address

City

ZIP Code

Verified By

County

(____)____-____
Phone

Applicant Demographics (*for civil service statistical purposes only)

Choose One or More: American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Hispanic or Latino*: Yes No **Gender:** Female Male

Marital Status: Single Married Divorced Separated Widowed

Proxy (A proxy form must be completed and be on-file in order for these persons to pick up food on your behalf – no more than two)

Persons authorized to pick up your food:

Name

(____)____-____
Phone

Name

(____)____-____
Phone

Household Composition

How many persons live at your address: _____ Are you living with a friend or relative: Yes No

Is the applicant, or any others living in the home Migrant Workers? Yes No In a homeless shelter? Yes No

Household Income (List all persons living in your home and include income for each person working or receiving benefits)

Persons who ARE Working (do not list yourself, list your income in the next section):

Name	Date of Birth	Hours Worked	Gross Income	Income Frequency
	/ /		\$	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input type="checkbox"/> Year
	/ /		\$	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input type="checkbox"/> Year

Persons who are NOT Working, retired persons, children (do not list yourself):

Name	Date of Birth	Name	Date of Birth
	/ /		/ /
	/ /		/ /

Applicant Income (attach proof for each income source – bank statements do not qualify as proof)

List dollar amounts of any other income (monthly, before deductions):

Child Support

DCF/General Asst.

Disability/SSI

Food Stamps

Foster Care Pay

Interest Income

Military Pay

Pension/Retirement

Self-Employed

Social Security

TAF

Unemployment

Wages

Other

Other Type

Verified By

Other

Has the applicant been on CSFP before? Yes No Currently On

By reading, signing and dating the back of this form, I acknowledge that the information provided is accurate and complete. I also understand that I must notify CSFP of all changes of income, address or household composition within 10 days.

This institution is an equal opportunity provider.



**YOUR RIGHTS AND RESPONSIBILITIES IN THE
KANSAS COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

I AGREE TO:

- ✓ Bring proof of income, address, and identification for each person applying.
- ✓ Give staff correct information about my current household and their income.
- ✓ Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

I UNDERSTAND THAT:

- ✓ CSFP will provide supplemental foods.
- ✓ CSFP will provide referrals to nutrition, health or assistance programs as appropriate.
- ✓ The CSFP local agency will provide nutrition education to all program participants.
- ✓ I will be dropped from this program if I participate in another CSFP Program.
- ✓ I have the right to appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.
- ✓ If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
- ✓ I may be taken off the program if I sell, trade, or give away CSFP foods.
- ✓ I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- ✓ I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- ✓ I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- ✓ Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits, and may lead to disqualification from CSFP.

This application form 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 once CSFP site at the same time. I am also aware that I may not receive CSFP benefits more than once a month at another site of CSFP.

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 of Participant, Adult Parent, or Caretaker

____/____/____
Date

Please mail completed forms and the following back to us:

ID or Driver's License and proof of income, i.e. Social Security statement. **Please note, we cannot accept bank statements for proof of income.**

Mail to: Kansas Food Bank
1919 E Douglas Ave
Wichita, KS 67211

If you have questions, or need assistance, please call:
Debi Kreutzman at (316) 265-3663

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