CSFP
Commodity Senior Food Program

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services (DAAS)
Coordinated Hunger Relief Program

HRP-1039A FORPD (8-17)

COMMODITY SENIOR FOOD PROGRAM (CSFP) PARTICIPANT RIGHTS AND OBLIGATIONS

Our Pledge to You

Supplemental Foods

- CSFP provides you with a supplemental food box once a month.
- CSFP will make nutrition education available to all participants, authorized representatives and proxies.

Fair Treatment

- CSFP rules are the same for everyone.
- You have a right to appeal a decision made by CSFP staff about your eligibility.

Privacy

- Unless you specifically authorize otherwise, all information you give to CSFP will be kept private.

Help Getting Enrolled in Other Services

- If you move to a different area, your CSFP information may be shared with the new CSFP agency.
- CSFP provides referrals to health and social services programs that may be able to help you.

By signing below, I agree to all of the rights and obligations listed on this form.

Your Pledge to CSFP

Honesty

- CSFP food benefits you, and you may not sell or trade the food (the intention alone may be grounds for removal from the program).
- If CSFP determines you have attempted to sell or had the intention to sell any food benefits verbally, in print or online, you will be subject to disqualification.
- You may enroll at only one CSFP location at a time and may not receive benefits at more than one CSFP location at the same time.
- ID/Transfer Cards are unique to you and must not be changed or altered.

Protect Your Benefits

- Keep your CSFP ID/Transfer Card safe.

Accurate Information

- Provide current and truthful information (CSFP staff may verify that the information is correct).

Good Use of the Program

- Be courteous and respectful toward CSFP staff.
- Following the rules of CSFP is important to avoid being disqualified from the program, prosecuted for program violations and/or asked to repay program benefits.

Client Name	Client Signature	Date
Authorized Representative 1 Name	Authorized Representative 1 Signature	Date
Authorized Representative 2 Name	Authorized Representative 2 Signature	Date
Agency Certifier Name	Agency Certifier Signature	Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services (DAAS)
Coordinated Hunger Relief Program

For DS use only:
Date:
Client ID#:
DS:

O TEFAP O CSFP

APPLICATION FOR BENEFITS

APPLICANT INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

GENDER *(Optional)*:

O Male O Female O Transgender O Undisclosed O Other

MARITAL STATUS *(Optional)*:

O Single O Married O Divorced O Separated O Widowed O Undisclosed O Common-Law

ADDRESS *(No., Street)* _____

CITY _____ COUNTY _____ STATE _____

ZIP CODE _____ PHONE NUMBER _____ ☐ No Fixed Address/Undisclosed

HOUSING TYPE *(Optional)*:

O Emergency Shelter/Mission/Transitional O Evacuee O Unhoused O Own Home O Private Rental
O Public (Social) housing O With Family/Friends O Youth Home/Shelter O Undisclosed O Other

LANGUAGE *(Optional)*: _____

ETHNICITY: *(Ethnicity is REQUIRED for CSFP)* ☐ White/Anglo ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Asian ☐ N/A ☐ American Indian/Native American ☐ Alaska Native/Aleut/Eskimo ☐ Middle Eastern/North African ☐ Other ☐ Undisclosed

SELF-IDENTIFIED AS *(Optional)*: ☐ Disabiltiy ☐ Undisclosed ☐ Veteran ☐ Mental Illness ☐ N/A ☐ Pregnant ☐ Postpartum ☐ Breastfeeding ☐ Other

AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

PROXY'S PRINTED NAME(S):

_____ _____ _____

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 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.) O **Yes** O **No**

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

APPLICANT'S NAME *(Please Print)* _____

APPLICANT'S SIGNATURE _____ DATE _____

See reverse for statements and form review.

HOUSEHOLD MEMBER INFORMATION 1

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

HOUSEHOLD MEMBER INFORMATION 2

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

HOUSEHOLD MEMBER INFORMATION 3

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

APPLICANT IS RECEIVING THE FOLLOWING

○ Supplemental Nutrition Assistacned Program (SNAP)
○ Commodity Supplemental Food Program (CSFP)
○ Other *(Specify)*:

See page 3 for USDA nondiscrimination and EOE/ADA/LEP/GINA, statements and form review.

HOUSEHOLD MEMBER INFORMATION 1

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

O Spouse O Child O Parent O Sibling O Grandparent O Other Relative O Boyfriend/Girlfriend
O Friend O Undisclosed

GENDER *(Optional)*:

O Male O Female O Transgender O Undisclosed O Other

HOUSEHOLD MEMBER INFORMATION 2

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

O Spouse O Child O Parent O Sibling O Grandparent O Other Relative O Boyfriend/Girlfriend
O Friend O Undisclosed

GENDER *(Optional)*:

O Male O Female O Transgender O Undisclosed O Other

HOUSEHOLD MEMBER INFORMATION 3

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

RELATIONSHIP

O Spouse O Child O Parent O Sibling O Grandparent O Other Relative O Boyfriend/Girlfriend
O Friend O Undisclosed

GENDER *(Optional)*:

O Male O Female O Transgender O Undisclosed O Other

APPLICANT IS RECEIVING THE FOLLOWING

O Supplemental Nutrition Assistacned Program (SNAP)
O Commodity Supplemental Food Program (CSFP)
O Other *(Specify)*:

See page 3 for USDA nondiscrimination and EOE/ADA/LEP/GINA, statements and form review.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or
(3) email: program.intake@usda.gov.
This institution is an equal opportunity provider.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.