CHECKSHEET - please return all of the following:

☐ Completed Application

☐ Signed Rights & Responsibilities (back page)

☐ ER Contact Form

☐ Proxy Form - if you select someone to pick up the box on your behalf.

If you need more than one proxy,
you will need to have another form
sent to you or you can make a copy.

☐ ID - Driver's License or State ID

☐ Proof of address if ID is not current: utility bill, credit card statement or rental receipt

Mail all of the above to:

Kansas Food Bank
Attn: Craig
1919 E Douglas
Wichita, KS 67211

Questions:
Call Craig
316-265-3663

JAN
2024

HOW DOES A SENIOR QUALIFY?

Look at the 2024 income guidelines **chart below:**

Household Size	Maximum Monthly Income
1.....	$1,632
2.....	$2,215
3.....	$2,798
4.....	$3,380
5.....	$3,963
6.....	$4,546
7.....	$5,129
8.....	$5,712

For each addition family member add:	$583

Kansas
Department for Children and Families

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)
PARTICIPANT APPLICATION

Is the applicant or any qualifying household member participating in CSFP at another site?
☐ YES ☐ NO
Improper use and receipt of the CSFP benefits as a result of dual participation or other **program violations may lead to a claim against the individual** to recover the value of the benefits and may lead to disqualification from the CSFP.

NAME OF APPLICANT		**DATE OF BIRTH**
ADDRESS		**COUNTY**
CITY	**STATE**	**ZIP CODE**
TELEPHONE NUMBER	**TOTAL NUMBER LIVING IN HOUSEHOLD**	

NAMES OF HOUSEHOLD MEMBERS	**AGE**	**DATE OF BIRTH**

For additional household members, use back of form.

CHANGES MUST BE REPORTED

Participants must report changes in household income or composition **within 10 days** after the change becomes known to the household.

Indicate the source and amount of current income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income would include commissions, strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.

HOUSEHOLD INCOME	**AMOUNT**	**HOW OFTEN RECEIVED**
Gross Salary, Wages		
Social Security		
Public Assistance (Welfare)		
Child Support (Alimony)		
Pensions/Retirement		
Self-Employment		
Unemployment		
Other Income		
Total Household Income		

RACIAL ETHNIC DATA (OPTIONAL) Mark your race? (Select one or more)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**

NAME OF APPLICANT

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the program are the same for everyone regardless of race, color, national origin, sex, age, and disability, or reprisal or retaliation for prior civil rights activity in any program, or activity conducted, or funded by USDA.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the program. Local agency will provide notification of a decision to deny or terminate CSFP benefits.
- ✓ You will be given nutrition, health, and social services referral information and are encouraged to seek needed assistance.
- ✓ You must report changes in household income or composition within 10 days after the change becomes known to the household.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.
- ✓ I am aware that deliberate misrepresentation may subject me to prosecution under applicable state and federal statutes.
- ✓ I am aware that I may not receive CSFP benefits at more than one CSFP site at the same time.
- ✓ I am aware that the information provided may be shared with other organizations to detect and prevent dual participation.

This application is being completed in connection with the receipt of federal assistance. Program officials may verify information on this form. 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 APPLICANT OR GUARDIAN ►	DATE
UPDATE INFORMATION, SIGN AND DATE FOR CERTIFICATION AFTER ON WAITING LIST ►	DATE

FOR CERTIFYING AGENCY USE ONLY

☐ IDENTITY/AGE VERIFIED-DESCRIBE PROOF PROVIDED	☐ RESIDENCY VERIFIED-DESCRIBE PROOF PROVIDED	☐ INCOME ELIGIBLE
☐ KDADS, SNAP, LIEAP INFO GIVEN	APPLICANT ELIGIBLE ☐ YES ☐ NO	☐ CASELOAD AVAILABLE ☐ YES ☐ NO
WRITTEN NOTICE GIVEN ☐ NOTICE OF CERTIFICATION STATUS ☐ NOTICE OF ADVERSE ACTION		DATE OF WRITTEN NOTICE
☐ ADDED TO WAIT LIST-DATE		DATE CERTIFIED
SIGNATURE AND TITLE OF CERTIFYING OFFICIAL		

PERIOD OF CERTIFICATION

BEGINNING MONTH/YEAR	ENDING MONTH/YEAR
DATE OF SECOND YEAR VERIFICATION (MONTH/YEAR)	DATE OF THIRD YEAR VERIFICATION (MONTH/YEAR)

CSFP Client Name:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

Do you have an email address:

_____

What Apartment Complex Do You Live At:

_____

Name of Manager:_____

Phone #:_____

Can we call the manager if you do not pick up your box? _____

REQUIRED - cannot be someone in the same household

Kansas Food Bank

Local Agency Name

CSFP PROXY FORM

During 2024 (year), I give permission for:

Proxy fill out

_____ (_____) _____ - _____

Name of Proxy — Proxy Phone Number

to pick up my CSFP foods. I certify that this person is at least 18 years of age.

Client Sign Here

_____ ____/____/20____

Signature of Responsible Party — Date

Name of Participant *(to be completed by staff)*	CSFP Case Number

Proxy Sign Here

_____ ____/____/20____

Signature of Proxy — Date

_____ ____/____/20____

Signature of CSFP Staff Member — Date

IMPORTANT REMINDER

The person you designate as your proxy must bring proof of his/her identification and this completed form to pick up and sign for your CSFP food. You are responsible for informing your proxy of food distribution schedules.

A copy of this form must be placed in each participant's file.

Mail completed form to: Kansas Food Bank, ATTN: Debi, 1919 E Douglas Ave, Wichita, KS 67211

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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