Michigan Commodity Supplemental Food Program Application

Questions marked with an * are optional.

First Name	MI	Last Name	DOB	# of People in Household	Form of Identification Shown

Ethnicity	Race – Check all that Apply
☐ Hispanic ☐ Non-Hispanic	☐ American Indian / Alaskan Native ☐ White ☐ Black / African American ☐ Asian ☐ Native Hawaiian / Other Pacific Islander

Physical Address	Mailing Address, if different*
Address:	Address:
City, State, Zip:	City, State, Zip:
County:	*Cell Phone:
*Home Phone:	*Email:

Income

Income Source	Amount	Frequency
Total Income:		

***Proxy Authorization** I authorize the following individual(s) or entity to pick up my USDA food box for me:	1._____ 2. _____

CSFP Client Agreement – COMPLETED BY THE APPLICANT
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 both CSFP and WIC benefits simultaneously, and 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. 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.) ***I have reviewed and agree to the CSFP Participant Rights & Responsibilities and Certification Statement above.*** ☐ **Yes** ☐ **No** **Customer Signature: _____ Date: _____**

CSFP Income Guidelines *Last updated 2/7/2024*	**Household of 1:** Annual income limit of $19,578 or a monthly income limit of $1,632 **Household of 2:** Annual income limit of $26,572 or a monthly income limit of $2,215 **Household of 3:** Annual income limit of $33,566 or a monthly income limit of $2,798 **For each additional family member add:** $6,994 annually, or $583 monthly

CSFP Eligibility Determination – STAFF USE ONLY	
CSFP Eligibility Criteria: • Self-declared household income is equal to or less than 130% FPL. • Applicant is at least 60 years of age. • Applicant resides in Agency service area.	**CSFP Eligibility Determination:** ☐ Approved ☐ Denied **CSFP Site:**

Intake Staff Printed Name: _____ **Intake Staff Signature: _____**

Date of Approval or Denial: _____ **Date of Written Notification: _____**

Initial Certification Date:		**Termination Date:**	
Wait List Date:		**Termination Reason:**	
Recertification Date:			
Recertification Date:			

CSFP Participant Rights and Responsibilities
• The Agency will provide written notification of approval or denial of the application within 10 days of receipt of the completed application. • If the application is denied, you have the right to appeal this decision by requesting a fair hearing within 60 days of notification. • Improper use or receipt of CSFP benefits because 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. • You must report changes in contact information (i.e., home address, phone number) or household income or composition within ten (10) days after the change becomes known to the household. • If you do not pick up commodity foods for three consecutive months, you may be considered an "inactive" CSFP participant and removed from the program. If you choose to remain a participant in CSFP, you must notify the Agency and participate within the current certification period of your original application date. • CSFP recipients who are removed from the program for being "inactive participants" can re-apply for benefits by filling out another CSFP application. If a waiting list exists, you will go on the list according to the date it was received. • Once a year, you will need to verify your address, income, and interest in continuing with the program. • This application is valid for three years and a new one will need to be filled out at that time. • The Agency will make nutrition education available to all participants and will encourage them to participate. • The Agency will provide information on other nutrition, health, or assistanceprograms, and make referrals as appropriate. • Standards for participation in this program are the same for everyone regardless of race, color, national origin, age, sex, and disability. • You are required to show proof of identity at each distribution.

Other Assistance

1. **The Supplemental Security Income (SSI) program**. This program pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. Phone: Toll-free at 1-800-772-1213 (TTY 1-800-325-0778). Online: www.ssa.gov/agency/contact
2. **Medical assistance**. Medicare is our country's health insurance program for people aged 65 or older. Phone: Toll-free at 1-800-772-1213 (TTY 1-800-325-0778). Online: www.medicare.gov
3. **Supplemental Nutrition Assistance Program (SNAP).** SNAP is a federal program that gives assistance for low-income individuals and families to purchase nutritious food. Individuals and families qualify for SNAP benefits based on their income. Phone: Toll-free at 1-888-678-8914. Online: www.michigan.gov/mdhhs

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: USDA Program Discrimination Complaint 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: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov This institution is an equal opportunity provider.

mid michigan COMMUNITY Action

"Helping People, Changing Lives."

Commodity Supplemental Food Program
Notice of Eligibility

Applicant Name:	
Applicant Address:	
Date of Application:	Date of Eligibility Determination:

Your application for participation in the Commodity Supplemental Food Program has been:

_____Approved

This application is valid for 3 years. Your eligibility will be re-certified annually. Upcoming distribution locations, dates, and times are included with this notice.

_____Denied

You are not eligible at this time for the reason(s) indicated below:

- ☐ Over Income
- ☐ Age
- ☐ Other (specify):

If you disagree with the denial, you can request a fair hearing with the agency. Present your request for a fair hearing verbally or in writing to the agency listed below. You have 60 calendar days to request a hearing when the denial of benefits was mailed or given to you. Contact our office for full details of the fair hearing policy. Program standards are applied without discrimination by race, color, national origin, age, sex, or disability.

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