

Michigan Commodity Supplemental Food Program Application

*Questions marked with an * are optional.*

First Name	MI	Last Name	DOB	# of People in Household
Ethnicity		Race – Check all that Apply		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander		
Physical / Mailing Address				
Address				
City, Zip, County				
*Phone / Email				

Categorical Eligibility - Current participation in (check one if applicable):

SNAP
 FDPIR
 SSI
 Low-Income Subsidy Program
 Medicare Savings Plan

If you checked a box above, you do not need to provide Income information below.

If you **do not** participate in the one of the above programs you **must** provide income information below.

Income		
Income Source	Income Amount	Income Frequency
Total Income:		

***Proxy Authorization** I authorize the following individual(s) or entity to pick up my CSFP 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

Applicant Signature: _____ **Date:** _____

CSFP Categorical Eligibility	CSFP Income Guidelines - Last updated 03/07/2025
Supplemental Nutrition Assistance Program (SNAP) Food Distribution Program on Indian Reservations Supplemental Security Income (SSI) Low-Income Subsidy Program Medicare Savings Programs	Household of 1: Annual income limit of \$23,475 or a monthly income limit of \$1,957 Household of 2: Annual income limit of \$31,725 or a monthly income limit of \$2,644 Household of 3: Annual income limit of \$39,975 or a monthly income limit of \$3,332 For each additional family member add: \$8,250 annually, or \$688 monthly

CSFP Eligibility Determination – STAFF USE ONLY

Verified Form of Identification	CSFP Eligibility Determination: <input type="checkbox"/> Approved <input type="checkbox"/> 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 approval/denial written notice within 10 days of receipt of the completed application.
- Participants have the to appeal a denial by requesting a fair hearing within 60 days of notification.
- Improper receipt or use of CSFP (dual participation or other program violations) may lead to a claim to recover the value and disqualification.
- Participants must report changes in contact information, household income or composition within ten (10) days of the change.
- Participants who do not pick up CSFP for three (3) consecutive months are considered “no show” and will be removed from the program.
- No Show CSFP recipients who are removed from the program can re-apply.
- If a wait list exists, participants will be added according to application dates.
- Participants will be recertified annually by verifying address, income, and interest in continuing with the program.
- This application is valid for three years. A new application will be needed after three years.
- The agency will make nutrition education available to all participants at each CSFP distribution.
- The agency will provide information on other nutrition, health, or assistance programs, 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.
- Participants are required to show proof of identity or verified address at each distribution.

Other Assistance – Please contact your local agency for additional information.

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 a federal 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 income eligible individuals and families to purchase nutritious food. Phone: Toll-free at 1-888-678-8914. Online: www.michigan.gov/mdhhs

4. **Seniors Farmers Market Nutrition Program / Senior Project Fresh.** This program provides coupons for income eligible residents 60 and older to use at local farmers markets. 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.