

**Kentucky Department of Agriculture
COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION/CERTIFICATION**

County #: _____

Local Agency ID: _____

Certification Site ID: _____

Applicant Information

Applicant Name:		Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Application Date:
Street Address:	City:	State: Kentucky	Zip code:	Phone Number:
Authorized Representative #1:	AR Phone Number:	Authorized Representative #2:	AR Phone Number:	

Racial/Ethnic Data (For Statistical Purpose Only)

Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> American Indian or Alaska Native and White	<input type="checkbox"/> Asian and White	<input type="checkbox"/> Black or African American and White	<input type="checkbox"/> American Indian or Alaska Native and Black or African American
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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.)

YES NO

Signature of Applicant: _____ 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.

The Kentucky Department of Agriculture does not discriminate on the basis of race, color, religion, gender, national origin, age (over 40), sexual orientation, gender identity, disability, genetics, ancestry or veteran status. Reasonable accommodations are provided upon request.

Gross Household Income: \$ _____ Source(s) of Income: _____

Monthly Semi-monthly Every 2 Weeks Weekly

Total Household Members _____ (Check box if included for CSFP)

List the name of all household members below and place a check in the box by the name of all CSFP participants.

Certification Data (To be completed by Program staff)

Action: <input type="checkbox"/> Initial <input type="checkbox"/> Re-certification #1 <input type="checkbox"/> Re-certification #2	Date: _____ _____ _____	Initial Certification Completion Date: _____	Re-certification Completion Date: _____
Classification: (Check appropriate box) <input type="checkbox"/> 6. Elderly (Age 60 & up) <input type="checkbox"/> 7. Elderly (Age 60 / Homebound)	Status: <input type="checkbox"/> Eligible (Participating) <input type="checkbox"/> Eligible (Placed on Waiting List) <input type="checkbox"/> Moved From Waiting List Date: _____ <input type="checkbox"/> Not Eligible <input type="checkbox"/> Closed/Terminated		
Documentation of Verification Method: <input type="checkbox"/> Categorical eligibility: _____ <input type="checkbox"/> Residence: _____	Reason not eligible or terminated: _____ Date Notice Sent: _____		

I hereby certify that this assessment was made on the basis of information contained within agency files. All eligibility criteria were applied as defined by the Kentucky Department of Agriculture Division of Food Distribution.

Signature of Agency Official: _____

Title: _____

Referrals

Indicate any referrals made to other service below: <input type="checkbox"/> WIC program <input type="checkbox"/> Food Stamp Program <input type="checkbox"/> Supplemental Security (SSI) <input type="checkbox"/> Other: _____	Documentation: Date: _____ Date: _____ Date: _____ Date: _____
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