

# \_\_\_\_\_

**MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION**  
Please complete a separate application for each person you are enrolling on the program.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Please indicate ONE OR MORE: (For civil service statistical purposes only) Are you . . .**

1) American Indian or Alaskan Native  
 Yes  No

2) Asian  
 Yes  No

3) Hispanic or Latino  
 Yes  No

4) Black or African American  
 Yes  No

5) Native Hawaiian or Other Pacific Islander  
 Yes  No

6) Caucasian  
 Yes  No

**IS THE APPLICANT:**

- Is the applicant 60 years old or older?  Yes  No
- Is the applicant currently receiving any benefits under the WIC (Women, Infants, & Children) Program?  Yes  No
- Is the applicant living with a friend or relative?  Yes  No

**INCOME:**

<b>Gross Income for all Members of the Family Unit</b>					
Current Income Limits based upon Federal Guidelines for the following period:			<b>July, 1, 2009 to June 30, 2010</b>		
<b>Family Unit Size</b>	<b>Weekly</b>	<b>Bi-Weekly</b>	<b>Semi-Monthly</b>	<b>Monthly</b>	<b>Annual</b>
1	\$273	\$546	\$587	\$1,174	\$14,088
2	\$367	\$734	\$790	\$1,580	\$18,960
3	\$461	\$922	\$992	\$1,984	\$23,808
4	\$556	\$1,112	\$1,195	\$2,389	\$28,668
5	\$650	\$1,300	\$1,398	\$2,795	\$33,540
6	\$744	\$1,488	\$1,600	\$3,199	\$38,388

How many persons live at your address and make up your family unit? \_\_\_\_\_

Is the applicant's gross family unit income less than the amount listed above?  Yes  No

Has the applicant been on CSFP before?  Yes  No

Is the applicant currently receiving CSFP?

Yes  No

**YOUR RIGHTS AND RESPONSIBILITIES IN THE  
MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

**I AGREE TO:**

- Provide proof of my income, address, and identification if requested.
- Give staff correct information about my current household and their income.
- Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

**I UNDERSTAND THAT:**

- CSFP will provide supplemental foods.
- CSFP will provide referrals to nutrition, health or assistance programs as appropriate.
- The CSFP local agency will provide nutrition education to all program participants.
- I will be dropped from this program if I participate in another CSFP or WIC Program.
- I have the right to appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.
- If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
- I may be taken off the program if I sell, trade, or give away CSFP foods.
- I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- Improper use or receipt of CSFP benefits as a result 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.

**CERTIFICATION**

This application form 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.

Yes  No 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.)

By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete and that I am not receiving any WIC benefits. I understand that I may not receive WIC and CSFP benefits at the same time and that I must notify CSFP of all changes of income, address or household composition within 10 days.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

In accordance with Federal law and U.S. Department of Agriculture policy, program standards are applied without discrimination by race, color, national origin, sex, sexual orientation, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY).

**STAFF USE ONLY:**

**Certifying Action Taken**

Approved \_\_\_\_\_ For period ending last day \_\_\_\_\_

Date Put on Waiting list if necessary \_\_\_\_\_

Denied \_\_\_\_\_ Letter of Fair Hearing Given \_\_\_\_\_

Date \_\_\_\_\_ Signature of Verifying & Determining Official \_\_\_\_\_