Name (Responsible Adult) __________________________________________

Address ________________________________________________________

(Number) (Street) (City) (Zip) (County) ________________________________

Phone __________________ Number in Household: ________

ID VERIFIED ☐ TYPE OF ID: ☐ Drivers License ☐ Birth Certificate ☐ SSN ☐ Other

Is the household participating in a program that meets CSFP eligibility criteria? Yes _____ No _____

If yes, what program? _____________________________________________

<table>
<thead>
<tr>
<th>Qualifying Household Members</th>
<th>Age</th>
<th>Date of Birth</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

RACIAL/ETHNIC DATA COLLECTION REQUIREMENT:
What is your ethnic category?: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your race? (Select one or more): ☐ American Indian or Alaskan Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

HOUSEHOLD INCOME: (Total Income Must Not Exceed 130% of the Current Federal Poverty Level Guidelines)

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount</th>
<th>How Often Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages, Salary</td>
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<tr>
<td>Social Security</td>
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<tr>
<td>Public Assist. (Welfare)</td>
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<tr>
<td>Pension/Retirement</td>
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<tr>
<td>Self-employment</td>
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<tr>
<td>Unemployment</td>
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<tr>
<td>Other (Specify)</td>
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<tr>
<td>Other (Specify)</td>
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</tr>
</tbody>
</table>

TOTAL HOUSEHOLD INCOME: ____________________________________________

I understand it is illegal to participate in the CSFP in more than one local agency.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Stop 9410, Washington, D.C. 20250-9410 or call toll free 866-632-9992 or call toll free 866-632-9992 Or you may use the Federal Relay for hearing impaired (800) 877-8339 or the Spanish relay (800) 845-7442. USDA is an equal opportunity provider and employer.

Please see reverse side of this form.
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) ____________________________

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUALS TO ACT AS MY AUTHORIZED REPRESENTATIVE FOR CSFP:

NAME ____________________________ RELATIONSHIP TO APPLICANT ____________________________

NAME ____________________________ RELATIONSHIP TO APPLICANT ____________________________

NEW CERTIFICATION: ID VERIFIED: ______ ELIGIBLE ______ NOT ELIGIBLE ______

CERTIFICATION DATE FROM ______ TO ______

TITLE OF CERTIFIER ____________________________ SIGNATURE ____________________________ DATE ______

2ND CERTIFICATION: ID VERIFIED: ______ ELIGIBLE ______ NOT ELIGIBLE ______

CERTIFICATION DATE FROM ______ TO ______

TITLE OF CERTIFIER ____________________________ SIGNATURE ____________________________ DATE ______

CLIENT CONTACT BY PHONE ______ IN PERSON ______

CLIENT WISHES TO REMAIN ON CSFP FOR A CONSECUTIVE SIX MONTHS? ______

CLIENT ADDRESS CHANGED? ______ IF YES, NEW ADDRESS ____________________________

IF INELEGIBLE PLEASE STATE REASON:

______________________________

• You will be notified of your eligibility, eligibility and placement on a waiting list, or ineligibility within 10 days of receipt of this correctly completed and signed application by the local CSFP agency.

• You may appeal any decision made by the local agency regarding your denial or termination from the program. You have a right to a fair hearing.

• If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.