Ohio Department of Job and Family Services

# COMMODITY SUPPLEMENTAL FOOD PROGRAM

## INCOME ELIGIBILITY GUIDELINES

## ELDERLY - 60 YEARS OF AGE & OLDER

Based on 130% of Federal Poverty Income Guidelines

| Household Size | Annual | Monthly | Weekly |
|---|---|---|---|
| 1 | $16,237 | $1,354 | $312 |
| 2 | $21,983 | $1,832 | $423 |
| 3 | $27,729 | $2,311 | $533 |
| 4 | $33,475 | $2,790 | $644 |
| 5 | $39,221 | $3,269 | $754 |
| 6 | $44,967 | $3,748 | $865 |
| 7 | $50,713 | $4,227 | $975 |
| 8 | $56,459 | $4,705 | $1,086 |
| For each additional family member add | $5,746 | $478.84 | $110.50 |

Income eligibility guidelines are established by the United States Department of Agriculture based on the current Federal Poverty Guidelines.

**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, religious creed, disability, age, political beliefs, 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.**

Ohio Department of Job and Family Services

# COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) CERTIFICATION

| **Return completed application to** |
|---|
| ***Street Address or Box Number*** |
| ***City, State Zip Code*** |

| Local Agency |
|---|
| Distribution Site |

## APPLICANT INFORMATION *PLEASE PRINT*

| Date | Applicant Last Name | First Name | Middle Initial | Date of Birth | Sex ☐ Male ☐ Female |
|---|---|---|---|---|---|
| | | | | | |

| Home Address *(Street Address or Box Number)* | City, State | County | Zip Code |
|---|---|---|---|
| | | | |
| Mailing Address *(Street Address or Box Number)* | City, State | County | Zip Code |
| | | | |

| Primary Telephone *(include area code)* | Number of People in Household |
|---|---|
| | |

| Income $ | How often is the income received? ☐ Weekly ☐ Yearly ☐ Monthly |
|---|---|
| | |

| Alternate Telephone *(include area code)* | Ethnicity - Are you Hispanic or Latino? ☐ Yes ☐ No | Race ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White | Handicap ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

| **Authorized Representative Information** | I authorize the following individual to act on my behalf in matters related to CSFP. | |
|---|---|---|
| **Authorized Representative** | Name | Phone *(include area code)* |
| | Address *(Street Address or Box Number)* | Zip Code |

| **Proxy Information** | In the event that I am unable to pick up my commodity food box from the distribution site, I authorize the following individual to pick up my commodity food box and sign the receipt log for me. I understand that I accept full responsibility for the actions of my proxy and will inform him/her of the proper procedure for commodity pick up. | |
|---|---|---|
| **Proxy** | Proxy #1 Name | Phone *(include area code)* |
| | Proxy #2 Name | Phone *(include area code)* |

**Please read the following statement carefully, then sign the form and write in today's date.**

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 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 responsibilities under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

**Your response to the following question does not affect consideration of this application.** 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

| Applicant Signature | Date |
|---|---|
| | |

## APPLICANT AGREEMENT

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. This application is being completed in connection with the receipt of Federal assistance.
3. Program officials may verify information on this form.
4. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
5. I may appeal any decision by the local agency regarding my eligibility for the CSFP. A request for a fair hearing can be submitted to the local agency.
6. The local agency will make health service and nutrition education materials available to me and I am encouraged to participate in these services.
7. I understand that participating in more than one CSFP program at the same time is not allowed and will result in being removed from the program.
8. **I understand that I may be dropped from the program if I fail to pick up my commodity food box two (2) months in a row with no communication.**
9. I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.
10. I understand CSFP is a supplemental rather than a total food program.
11. I consent to the release of information by program staff to another CSFP agency to which I may transfer, and to officials of USDA and the Ohio Department of Job & Family Services.
12. I understand that I must report changes in household income, or changes in the composition of the household, within ten days after the change becomes known to the household.
13. I understand that physical abuse, or the threat of physical abuse, of CSFP staff is a program violation. My participation in CSFP may be terminated for this and for other program violations.
14. I have been advised on my rights and responsibilities under the CSFP.

**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 file a Program Discrimination Complaint as a USDA Customer | Office of the Assistant Secretary for Civil Rights 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.**

## TO BE COMPLETED BY PROGRAM STAFF

| Date of Initial Application Received | Eligibility | | | Determination | Date Certified/Denied |
|---|---|---|---|---|---|
| | Income | ☐ YES | ☐ NO | ☐ Eligible | |
| | Residency | ☐ YES | ☐ NO | ☐ Not Eligible | Certification Period: |
| | Age | ☐ YES | ☐ NO | ☐ Eligible and On Waiting List | From to |

I hereby certify that this assessment was made in compliance with federal and state program guidelines. All eligibility criteria were applied as defined by the ODJFS.

| Signature | Title | Date |
|---|---|---|
| | | |

| Date Recertification Due By: | In order to continue receiving CSFP benefits, you will need to complete the recertification process. |
|---|---|

**Notes:**

**Commodity Supplemental Food Program Application**
**Verification of Documentation Form**

Applicant Name: _____

County: _____

☐ **Picture Identification**

☐ **Proof of Date of Birth**

☐ **Proof of Residency**

By my signature, I verify that I have viewed the above checked documents verifying the applicant's identity, age, and residency:

_____ _____ _____

***Signature of staff person taking application*** ***Date***

Are you currently receiving food stamp assistance? If yes, how much? ☐YES ☐NO $_____

If "no", do you want information about Food Stamp Assistance in addition to CSFP? ☐YES ☐NO

Miami Valley Community Action Partnership
Helping People. Changing Lives.

# Miami Valley Community Action Partnership
# CSBG Customer Intake Application

| Client Number: | Program Name: | Application Date: |
|---|---|---|
| | ☐ Emergency Services ☐ HEAP ☐ Winter Crisis ☐ Summer Crisis ☐ PIPP+ ☐ Housing ☐ Commodity box ☐ Emergency Pantry ☐ Getting Ahead | |

## Primary Applicant

| First Name: | M.I.: | Last Name: |
|---|---|---|
| **Social Security Number:** | **Date of Birth:** | **Gender:** ☐ Female ☐ Male ☐ Other |
| **Disabled:** ☐Yes ☐ No | **Veteran:** ☐Yes ☐ No | **Food Stamps:** ☐Yes ☐ No |

Current Residential Address:

Current Mailing Address (if different from above):

| City: | State: | Zip Code: | County: |
|---|---|---|---|
| Phone Number: | | Email Address: | |

**Race:**
☐ American Indian/Alaskan Native ☐ Asian
☐ Black/African American ☐ White
☐ Native Hawaiian/Other Pacific Islander
☐ Unknown/not reported ☐ Other

**Education:**
☐ 0-8
☐ 9-12 (Non Grad)
☐ HS Grad/GED
☐12 + Post-Secondary ☐ 2-4 Yr. Grad College

**Ethnicity:**
☐ Hispanic, Latino or Spanish Origins
☐ Not Hispanic, Latino or Spanish Origins

## Household Information:

**# In Household:**

**Housing Status**
☐ Own
☐ Rent
☐ Other Permanent Housing
☐ Homeless
☐ Other

**Family Type**
☐ Single Parent/Female
☐ Single Parent/Male
☐ Two-Parent Household
☐ Single Person
☐ Two Adults/No Children
☐ Non-related Adults with children
☐ Multigenerational Household
☐ Other

**Building Type**
☐ Mobile Home
☐ Single Family
☐ Multi-family low- rise (3 stories or less)
☐ Multi-family high-rise (3 stories or more)

**Work Status**
☐ Employed full-time
☐ Employed part-time
☐ Migrant Seasonal Farm Worker
☐ Unemployed (short-term, 6 months or less)
☐ Unemployed (long-term, more than 6 months)
☐ Unemployed (not in labor force)
☐ Retired
☐ Unknown/not reported
☐ Youth ages 14-24 who are neither working nor in school

**Health Insurance Type**
☐ Medicaid
☐ Medicare
☐ Private/Employment
☐ Self-Insured/Direct Pay
☐ None
☐ State Children's Health Insurance Program
☐ State Health Insurance for Adults

**Source of Income:**
☐ Employment ☐ Unemployment ☐ Self-Employment ☐ No Income ☐ Social Security
☐ TANF/ADC ☐ SSI/SSD ☐ Pension ☐ Disability ☐ Child Support
☐ Other (Please Specify) _____

**Income Period:**
☐ Weekly ☐ Bi-Weekly
☐ Monthly ☐ Yearly

**Income Amount:**

## Household Members:

| | | | | | | |
|---|---|---|---|---|---|---|
| Last Name: | | | | | | |
| First Name: | | | | | | |
| Social Security # | | | | | | |
| Date of Birth: | | | | | | |
| Gender: | | | | | | |
| Race: | | | | | | |
| Education: | | | | | | |
| Ethnicity: | | | | | | |
| Disabled Y/N: | | | | | | |
| Veteran Y/N: | | | | | | |
| Health Insurance: | | | | | | |
| Relationship (i.e. daughter, son, spouse etc.) | | | | | | |
| Income source: | | | | | | |
| Income Amount: | | | | | | |

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

*Miami Valley Community Action Partnership*

# AUTHORIZATION FOR INFORMATION EXCHANGE

By signing this authorization, I grant permission for the sharing of information which is to be used to determine eligibility for participation in the Community Services Block Grant (CSBG) or other agency programs under the umbrella of Community Action as operated by the Miami Valley Community Action Partnership for either myself or my family members.

I understand this release will terminate one year from the date I sign this authorization or sooner if I request so in writing.

I understand that all information obtained in association with this release will be held in strict confidence by the recipient.

I further direct that information shared resulting from my signature not be further disclosed without my specific written authorization.

I further declare that I understand and permit an information exchange strictly for disclosure purposes related to Miami Valley Community Action Partnership programming.

I also hereby give permission to release to and /or secure information from the following organizations for the purpose of securing services I have requested:

_____

_____

_____
Customer Name (Printed)

_____ _____
Customer Signature Date

_____ _____
MV Community Action Partnership Staff Signature Date

Miami Valley community Action™ PARTNERSHIP
*Helping People. Changing Lives.*

*Tear off this section and give it to the applicant*

## APPLICANT AGREEMENT

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13. I understand that physical abuse, or the threat of physical abuse, of CSFP staff is a program violation. My participation in CSFP may be terminated for this and for other program violations.
14. I have been advised on my rights and responsibilities under the CSFP.

## REQUESTING A FAIR HEARING

**If I am dissatisfied with any decisions made regarding the eligibility or receipt of benefits, the following procedure may be followed:**

15. I may talk with the CSFP workers at this distribution site, contact the local CSFP program director, or the CSFP State Program Director at the Ohio Department of Job & Family Services to have my case reviewed.
16. If I am not satisfied with the explanation of the workers or the local program director, I may request a fair hearing by mail, verbally, or present a written request in person to the local program director. My request should be made within 60 calendar days from the date the local agency mailed or gave me notice of denial or termination of benefits.
17. I will be contacted by the State Program Director or his/her designated representative within a week after my request is received. At this time, a date will be set for the hearing. I will be notified at least 10 calendar days before the hearing. The hearing will be held within 21 calendar days of receipt of the request for a fair hearing.
18. I may present my position personally or select a representative to do so. If my representative or I cannot appear at the scheduled time and place, I may request the hearing officer to change it. I will be provided one opportunity to reschedule the hearing date upon written request submitted to the CSFP Office at the Ohio Department of Job & Family Services.
19. If I do not appear for the hearing or if my authorized representative or I request the hearing to be canceled, it will be canceled.
20. The local program director and I will be sent a written decision concerning the hearing within 45 calendar days after the hearing was requested.
21. The CSFP local agency must follow the decision. I must follow the decision also.
22. If I do not agree with the decision made at the local hearing, I may ask for an appeal by contacting the state agency as follows: CSFP-Office of Family Assistance, Ohio Department of Job & Family Services, 4020 East 5th Ave. PO Box 183204, Columbus, OH 43218-3204. If I desire an appeal, a request for a rehearing must be filed within 10 calendar days after the receipt of the fair hearing decision.
23. The detailed Fair Hearing Procedures are on file with the local agency CSFP director. A copy is available upon request.