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## 2020-2021 MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

Please complete a separate application for each person you are enrolling in the program.

RETURN THIS APPLICATION Aroostook Area Agency on Aging; PO BOX 1288; Presque Isle, ME 04769

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_  
County \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Physical Address (if different from above) \_\_\_\_\_

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:

Gross Income for all Members of the Family Unit				
Family Unit Size	Weekly	Bi-Weekly	Monthly	Annual
1	\$319	\$692	\$1,383	\$16,588
2	\$431	\$934	\$1,868	\$22,412
3	\$543	\$1,177	\$2,353	\$28,236
4	\$655	\$1,420	\$2,839	\$34,060
5	\$767	\$1,662	\$3,324	\$39,884
6	\$879	\$1,905	\$3,809	\$45,708

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?  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. It may also lead to disqualification from CSFP.

**CERTIFICATION**

This application form is being completed in connection with receipt of Federal Assistance. I am aware that program officials may need to verify information on this form and that I am obligated to cooperate. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes.

I certify that I will not receive both CSFP and WIC benefits simultaneously, and I will not receive CSFP benefits at more than one CSFP site concurrently. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation.

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

**By checking this box, I am indicating that I do not want my personal information released to other organizations administering assistance programs for use in determining my eligibility for participation in this and other public assistance programs and for program outreach purposes. I understand that this may result in my not being approved for this program.**

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, 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, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (866) 632-9992(TDD) or (866) 377-8642 (Relay Voice Users). USDA is an equal opportunity provider and employer.

The Maine Department of Agriculture, Conservation, & Forestry does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1975 and the Maine Human Rights Act.

**Any questions please contact the agency that provided this application.**

**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 \_\_\_\_\_