FD-CSFP-01
1/19

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: ☐ M ☐ 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? ☐ Yes ☐ No	☐ Asian ☐ White	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ American Indian or Alaskan Native	☐ American Indian or Alaska Native and White	☐ Asian and White	☐ Black or African American and White	☐ American Indian or Alaska Native and Black or African American

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: Date:	Initial Certification Completion Date:	Re-certification Completion Date:
☐ Initial _____ ☐ Re-certification #1 _____ ☐ Re-certification #2 _____	_____	_____

Classification: (Check appropriate box)	Status:
☐ 6. Elderly (Age 60 & up) ☐ 7. Elderly (Age 60 / Homebound)	☐ Eligible (Participating) ☐ Eligible (Placed on Waiting List) ☐ Moved From Waiting List Date:_____ ☐ Not Eligible ☐ Closed/Terminated
Documentation of Verification Method: ☐ Categorical eligibility: _____ ☐ 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:	Documentation:
☐ WIC program Date: _____ ☐ Food Stamp Program Date: _____ ☐ Supplemental Security (SSI) Date: _____ ☐ Other: _____ Date: _____	