

# PARTICIPANT APPLICATION

## COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

Name: Charlie Brown

Date of birth: 10 / 1 / 1950 Number of people in household: 2

### CSFP Income Eligibility Guidelines

Effective January 26, 2023

Based on 130% of Federal Poverty Guidelines			
Household Size	Yearly	Monthly	Weekly
1	\$18,954	\$1,580	\$365
2	\$25,636	\$2,137	\$493
3	\$32,318	\$2,694	\$622
4	\$39,000	\$3,250	\$750
5	\$45,682	\$3,807	\$879
6	\$52,364	\$4,364	\$1,007
For each extra person, add:	+\$6,682	+\$557	+\$129

List the total gross income of all household members before any deductions or expenses. SNAP benefits do not count as income.

\$ \_\_\_\_\_ Yearly or \$ 1,900 Monthly or \$ \_\_\_\_\_ Weekly

Address: 123 Peanuts Ln Unit/apt. number: B

City: Austin Zip code: 78701 Phone number (optional): \_\_\_\_\_

Ethnicity (select one):  Hispanic or Latino  Not Hispanic or Latino

Race (select one or more):

Black or African American  Native Hawaiian or Other Pacific Islander

American Indian or Alaskan Native  Asian

White

### AUTHORIZATION OF PROXY (optional)

Participants may designate proxies who can sign and pick up food on their behalf.

Name of proxy: Sally Brown

Phone number of proxy: \_\_\_\_\_

This proxy authorization starts today and lasts until the end of the 3-year certification period unless a specific end date is provided here: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

CONTINUED ON REVERSE 

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 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 have received notice of my **Participant Rights and Responsibilities** (Form 1516).  Yes

A **Written Notice of Beneficiary Rights** was made available.  Yes

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 a decision by placing a checkmark in the appropriate box.)  Yes  No

**Applicant or Proxy's Signature:** Charlie Brown **Date:** 2, 15, 2023

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling, (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form or letter must be submitted 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

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**INTAKE STAFF OR VOLUNTEER ONLY**

**Site name:** Schulz Rec Center

**Eligible** — Applicant is eligible when they meet income, residency, and age requirements.

**Dates of certification:** 2, 15, 2023 to 2, 28, 2026

**Eligible and on wait list**

**Ineligible** — I have been advised in writing that I am ineligible to participate in the CSFP and have the right to a fair hearing. I am ineligible to participate based on the following criteria:  **Income**  **Residency**  **Age**

**Certifier signature:** Elizabeth Bar



# CTFB SUPPLEMENTAL INTAKE FORM

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**The following questions are optional and will not affect your ability to receive food assistance.**

*If you prefer not to answer this section, skip these questions and turn in your form.*

1. Email Address: \_\_\_\_\_

2. What additional assistance do you receive? **(Please check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)                   | <input checked="" type="checkbox"/> Social Security   |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF)                     | <input type="checkbox"/> Texas Women's Health Program |
| <input type="checkbox"/> National School Lunch Program (NSLP) (free or reduced-price meals) | <input type="checkbox"/> Veterans' Benefits           |
| <input type="checkbox"/> Supplemental Security Income (SSI)                                 | <input type="checkbox"/> WIC                          |
| <input type="checkbox"/> Medicaid   | <input type="checkbox"/> Medicare                     |
|   | <input type="checkbox"/> CHIP                         |
|   | <input type="checkbox"/> Other: _____                 |

3. Gender:     Female     Male     Other     Prefer not to answer

4. How many **children (0-17)** live in your household?    0

5. How many **people 60 and older** live in your household?    2

6. How many **veterans** live in your household?    0

7. How many **active-duty military members** live in your household?    0

8. How many **college students** live in your household?    0

9. What is your preferred language?

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> English     | <input type="checkbox"/> 'heɪʃən 'kri:oʊl (Haitian Creole)   |
| <input type="checkbox"/> Español (Spanish)      | <input type="checkbox"/> हिन्दी (Hindi)                      |
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> 한국어 / 조선말 (Korean)                  |
| <input type="checkbox"/> العربية (Arabic)       | <input type="checkbox"/> پښتو (Pashto)                       |
| <input type="checkbox"/> Bosanac (Bosnian)      | <input type="checkbox"/> Kiswahili / كِسْوَاهِيلِي (Swahili) |
| <input type="checkbox"/> မြန်မာအက္ခရာ (Burmese) | <input type="checkbox"/> ትግርኛ (Tigrigna / Tigrinya)          |
| <input type="checkbox"/> 中文 (Chinese)           | <input type="checkbox"/> Tiếng Việt (Vietnamese)             |
| <input type="checkbox"/> tʃɛk (Czech)           | <input checked="" type="checkbox"/> Other                    |
| <input type="checkbox"/> Français (French)      | <u>wah wah adult voice</u>                                   |

**Central Texas Food Bank Client Release of Information**

I acknowledge my information will be stored in a secure database, Oasis Insights, and used by CTFB and the pantry providing assistance to improve services offered to my community and me. Any reports that use my data will not reveal my identity.

By consenting to release my information, I agree to share my information with the Central Texas Food Bank (CTFB) and their partners to make it easier for me to access food at other pantries in the CTFB network. By not consenting, I agree only to share my information with this agency and CTFB.

- YES                       NO



## Welcome to CSFP!



**What is CSFP?** The Commodity Supplemental Food Program (CSFP) provides older adults ages 60+ with cheese and a box of shelf-stable groceries every month. The Central Texas Food Bank runs this program.

The Texas Department of Agriculture recommends that you use all the food in your CSFP package yourself.

### When and where can I get my monthly box?

Location: Schulz Rec Center

Date: 1st Friday every month

Time: 11 AM - 12 PM

Remember your ID!

### Can someone else pick up my box for me? Can I pick up a box for someone else?

Yes! A CSFP participant can authorize a proxy to pick up a box and act on their behalf. Ask CSFP distribution staff or a volunteer how to get started.

### If I miss the distribution, can I get my box later?

Contact the Food Bank—you may be able to get a box at a different location later in the month. Once the month is over, you will not be able to get a make-up box.

If the Food Bank has reached its maximum number of CSFP participants and you miss two distributions in a row, you may be removed from CSFP and need to reapply.

**Questions?** Contact the Central Texas Food Bank at 512-282-2111 or [distributionprograms@centraltexasfoodbank.org](mailto:distributionprograms@centraltexasfoodbank.org).

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Commodity Supplemental Food Program  
**Participant Rights and Responsibilities**

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. CSFP benefits are provided in connection with the receipt of federal assistance. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under state and federal law.
3. I may appeal any decision made by the food pantry or food bank regarding my eligibility for CSFP. A request for a fair hearing can be submitted to the food pantry or to the food bank by telling them I want to appeal.
4. Health services referrals and nutrition education will be made available to me and I am encouraged to participate in these services.
5. I understand that I can request a referral to a non-religious site.
6. I understand that participating at more than one CSFP site at the same time is not allowed and might lead to disqualification from CSFP.
7. I understand that I must report changes in household income, or changes in the composition of the household, within ten days.
8. If approved for participation in CSFP, consecutive failure to pick up food as directed may result in being dropped from CSFP with 15 days' written notice.
9. I understand that if I choose to send a proxy (an alternate person) to pick up my food, the proxy must 1) be listed as a proxy on my Participant Application or in my file, 2) present my appointment card, if requested, 3) provide his or her identification, and 4) sign for the food package.
10. I understand that the food provided by CSFP is intended for the participants for whom they are supplied.
11. I consent to the release of information to the following: 1) CSFP staff 2) another CFSP agency, if I wish to transfer; 3) other health or welfare programs, to prevent dual participation; 4) USDA; 5) TDA; 6) the food pantry; or 7) the food bank.
12. I have been advised of my rights and obligations under CSFP.
13. I understand that I must not sell nor exchange USDA Foods for nonfood items.
14. 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.

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