

**Participant Application**

Print pages 1 – 2 for **Certification**.

**Household Information**

<b>Name of applicant/Nombre del solicitante</b>	<b>Address/Dirección</b>	<b>Date/Fecha</b>
<b>Date of birth/La fecha de nacimiento</b>	<b>Phone number/Número de teléfono</b>	<b>Site name/Nombre del sitio</b>
<b>Name of proxy/Nombre del proxy</b>	<b>Phone number/Número de teléfono</b>	<b>Dates of proxy/Fechas de proxy</b>

**Federal Assistance Program Participation/Participación en Programas de Asistencia Federal**

Do you currently participate in any of the federal assistance programs listed below? **If Yes**, select the applicable program(s) and skip to the Eligibility section. **If No**, complete the Income Information section below. / ¿Participa actualmente en alguno de los programas de asistencia federal que se enumeran a continuación? En caso afirmativo, seleccione los programas correspondientes y pase a la sección Elegibilidad. En caso negativo, complete la sección Información de ingresos a continuación.

**SNAP**  **Supplemental Security Income/Seguridad de Ingreso Suplementario (SSI)**

**Low Income Subsidy Program (Medicare Part D Extra Help)/Ayuda Adicional de Medicare Parte D**

**Medicare Savings Program/Programa de Ahorros de Medicare**

**Income Information**

**Total gross income (before deductions) of all household members. SNAP benefits do not count as income.**  
Ingreso brutos total (antes de deducciones) de todos los miembros del hogar. *Beneficios de SNAP no cuentan como ingreso.*

\$ \_\_\_\_\_ **Weekly/Semanal**                      \$ \_\_\_\_\_ **Monthly/Mensual**                      \$ \_\_\_\_\_ **Yearly/Anual**

\_\_\_\_\_ **Number of household members/Número de miembros del hogar**

**Eligibility**

**Eligible/Eligible** Applicant is eligible when they meet income, residency, and age requirements./El solicitante es elegible cuando cumple con los requisitos de ingresos, residencia, y edad.

**Dates of certification/Fechas de la certificación:** from/de \_\_\_\_\_ to/a \_\_\_\_\_

**Eligible and on waitlist/Eligible y en la lista de espera**

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**Ineligible/Inelegible** 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:/He sido informado por escrito que soy inelegible para participar en el programa de comida suplemental y tengo derecho a una audiencia imparcial. Soy inelegible para participar en base a los siguientes criterios:

\_\_\_\_\_ **Income/Los ingresos**                      \_\_\_\_\_ **Residency/La residencia**                      \_\_\_\_\_ **Age/La edad**

**Nondiscrimination Statement**

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, 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, audiotope, 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/ad-3027.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; or  
(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

**This institution is an equal opportunity provider.**

**Declaración de No Discriminación**

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo, discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: <https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf>, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) correo: U.S. Department of Agriculture; Office of the Assistant Secretary for Civil Rights; 1400 Independence Avenue, SW; Washington, D.C. 20250-9410; or (2) fax: (833)256-1665 o (202) 690-7442; o (3) correo electrónico: [program\\_intake@usda.gov](mailto:program_intake@usda.gov).

**Esta entidad es un proveedor que ofrece igualdad de oportunidades.**

**Ethnicity and Race**

<b>Ethnicity</b> (select one category)/Origen étnico (seleccione una categoría)	
<input type="checkbox"/> <b>Hispanic or Latino</b> /Hispano o Latino _____	<input type="checkbox"/> <b>Not Hispanic or Latino</b> /No hispano o Latino _____
<b>Race</b> (select one or more categories)/Raza (seleccione una o más categorías)	
<input type="checkbox"/> <b>Black or African American</b> /Negro o afroamericano	
<input type="checkbox"/> <b>Native Hawaiian or Other Pacific Islander</b> /Nativo de Hawai o de otra isla del Pacifico	
<input type="checkbox"/> <b>American Indian or Alaskan Native</b> /Indio americano o nativo de Alaska	
<input type="checkbox"/> <b>Asian</b> /asiático	
<input type="checkbox"/> <b>White</b> /el blanco	

**Certification Statement**

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 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

I have received notice of my *Participant Rights and Responsibilities* (Form1516). Yes

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

Esta solicitud se está llevando a cabo en relación con el recibo de asistencia federal. Oficiales del programa pueden verificar la información en este formulario. Soy consciente de que una tergiversación deliberada puede someterme a un proceso judicial conforme a los estatutos estatales y federales aplicables. También soy consciente que no puedo recibir beneficios de CSFP en más de un sitio de CSFP al mismo tiempo. Además, soy consciente de que la información proporcionada puede ser compartida con otras organizaciones para detectar y prevenir la doble participación. He sido informado de mis derechos y obligaciones bajo el programa. Yo certifico que la información que he proporcionado para mi determinación de elegibilidad es correcta a lo mejor de mi conocimiento.

Autorizo la divulgación de la información proporcionada en este formulario de solicitud a otras organizaciones que administran programas de asistencia para su uso en la determinación de mi elegibilidad para participar en otros programas de asistencia pública y para fines de divulgación del programa.  
(Indique la decisión colocando una marca de verificación en el cuadro apropiado.) Sí  No

He recibido aviso de mi *Derechos y Responsabilidades del Participante* (Form1516). Sí

Se hizo disponible la *Notificación por Escrito de los Derechos del Beneficiario*. Sí

**Signatures**

<b>Applicant or Proxy's Signature</b> /Firma del participante o representante	<b>CE or Site's Signature</b> /CE o firma del sitio

# 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 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? \_\_\_\_\_

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

6. How many **veterans** live in your household? \_\_\_\_\_

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

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

9. What is your preferred language?

- |   |  |
|---|--|
| <input type="checkbox"/> English                | <input type="checkbox"/> 'heɪfən 'kri:ɔʊl (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 / كِسْوَهِيل (Swahili)  |
| <input type="checkbox"/> မြန်မာအက္ခရာ (Burmese) | <input type="checkbox"/> ትግረኛ (Tigrigna / Tigrinya)        |
| <input type="checkbox"/> 中文 (Chinese)           | <input type="checkbox"/> Tiếng Việt (Vietnamese)           |
| <input type="checkbox"/> tʃɛk (Czech)           | <input type="checkbox"/> Other                             |
| <input type="checkbox"/> Français (French)      |  |
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### 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



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 referral information for other federally-funded programs in my area.
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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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.

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## Written Notice of Beneficiary Rights

Name of Organization: \_\_\_\_\_

Name of Applicable Program:

- The Emergency Food Assistance Program (TEFAP)
- Commodity Supplemental Food Program (CSFP)

Because the Program(s) indicated above are supported in whole or in part by financial assistance from the Federal Government, we are required to let you know that:

- We may not discriminate against you on the basis of religion or religious belief; a refusal to hold a religious belief; or a refusal to attend or participate in a religious practice;
- We may not require you to attend or participate in any explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization) that are offered by our organization, and any participation by you in such activities must be purely voluntary;
- We must separate in time or location any privately funded explicitly religious activities (including activities that involve overt religious content such as worship, religious instruction, or proselytization) from activities supported with direct Federal financial assistance; and
- You may report violations of these protections, including denials of services or benefits, by an organization, by contacting or filing a written complaint with the

U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights Executive Director  
Center for Civil Rights Enforcement  
1400 Independence Avenue SW  
Washington, DC 20250-9410, or by email to [program.intake@usda.gov](mailto:program.intake@usda.gov)

- If you would like to seek information about whether there are any other federally funded organizations that provide these kinds of services in your area, please contact the USDA Hunger Hotline:

By Phone: 1-866-3-HUNGRY or 1-877-8-HAMBRE to speak with a representative from 7:00 AM – 10:00 PM Eastern Time.

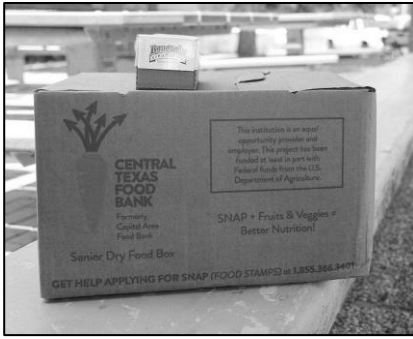
By Text: 914-342-7744 with a question that may contain a keyword such as “food,” “summer,” “meals,” etc. to receive an automated response to resources located near an address and/or zip code.

**NOTE:** You may also contact TDA at 877-TEX-MEAL (877-839-6325) or [SquareMeals@TexasAgriculture.gov](mailto:SquareMeals@TexasAgriculture.gov).

This written notice must be given to you before you enroll in the program or receive services from the program, unless the nature of the service provided or exigent circumstances make it impracticable to provide such notice before we provide the actual service. In such an instance, this notice must be given to you at the earliest available opportunity.

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## 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:

Date:

Time:

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  
**Income Eligibility Guidelines for the Elderly**  
***Pautas de Elegibilidad de Ingresos Para Personas Mayores***

Effective March 7, 2025<sup>1</sup>  
Efectivo el 7 de Marzo de 2025<sup>2</sup>

60 Years of Age and Older  
60 Años de Edad y Más

Based on 130% of Federal Poverty Guidelines  
Basado en el Nivel Federal de Pobreza del 130%

Household Size <i>Tamaño del hogar</i>	Annual Income <i>Ingresos Anuales</i>	Monthly Income <i>Ingresos Mensuales</i>	Weekly Income <i>Ingresos Semanales</i>
1	\$20,345	\$1,696	\$392
2	\$27,495	\$2,292	\$529
3	\$34,645	\$2,888	\$667
4	\$41,795	\$3,483	\$804
5	\$48,945	\$4,079	\$942
6	\$56,095	\$4,675	\$1,079
7	\$63,245	\$5,271	\$1,217
8	\$70,395	\$5,867	\$1,354
For each additional household member, add/ <i>Por Cada miembro adicional del hogar, sume:</i>	\$7,150	\$596	\$138

<sup>1</sup> Pursuant to program regulations, the 2025 elderly income guidelines must be implemented immediately upon receipt of notification from USDA and will remain in effect until notification of the income guidelines for 2026.

<sup>2</sup> De conformidad con las regulaciones del programa, las pautas de ingresos para personas mayores de 2025 deben implementarse inmediatamente después de recibir la notificación del USDA y permanecerán en vigor hasta la notificación de las pautas de ingresos para 2026.