

## Instructions for CSFP (Senior Commodities) Application Completion.

(MUST BE 60 YEARS OF AGE TO PARTICIPATE IN CSFP.)

**Name and Date of Birth:** Fill in the applicant's name and date of birth. **Proof of name and date of birth must be provided.** Acceptable forms of proof include: driver's license, state issued identification card, state issued birth certificate, hospital issued certificate of live birth, or passport.

**Address, City, Zip Code, and County:** Fill in the applicant's current address. **Proof of current address must be provided.** Acceptable forms of proof include: driver's license, state issued identification card, bills mailed to the address, lease, and rent receipts.

**Mailing Address:** If the applicant's mailing address differs from the applicant's physical address, **please write the mailing address in the margin of the application** since the application does not provide a place for it.

**Phone Number:** List any phone numbers that can be used to reach the applicant, if applicable.

**Living Arrangements:** Write the number of people live at the applicant's.

**Household Members:** List all persons living in the household (other than applicant). Also list each person's age and date of birth

**Household Income:** In the amount column, **list the dollar amounts** for each type of income on the list. **Note: provide the amount before deductions (gross income).** In the How Often Received column, indicate if the income is weekly, bi-weekly, monthly, etc. If you receive food stamps, please write that amount of the line for Public Assistance and write food stamps in the how often received column.

CSFP Gross Income Limit - 130% of Federal Poverty Income Guidelines (MUST COUNT ALL INCOME FOR ALL PEOPLE LIVING IN THE HOME)		
Household Size	Monthly Income	Annual Income
1	\$1,696	\$20,345
2	\$2,292	\$27,495
3	\$2,888	\$34,645
4	\$3,483	\$41,795
5	\$4,079	\$48,945
6	\$4,675	\$56,095

**Race/Ethnicity:** Circle one or more of the race options as they pertain to applicant. Check whether or not the applicant considers themselves to be of Hispanic or Latino ethnicity. **Note: These are for statistical purposes only and must be reported by DCF to USDA annually.**

### Back of the Application:

1. Read your rights and responsibilities.
2. Release of information statement: check yes or no.
3. **DON'T FORGET TO SIGN AND DATE THE APPLICATION.**

**ATTENTION!! IF YOU WOULD LIKE SOMEONE TO BE ABLE TO PICK UP YOUR FOOD BOX FOR YOU (PROXY):** Up to two people can be authorized to pick up the applicant's commodities. The applicant will need to complete a proxy form for each person. The proxy form is valid for one year so to maintain authorization, the form must be renewed annually. The proxy form will be provided upon request.

### **SUBMIT YOUR APPLICATION, PROOF OF NAME/DATE OF BIRTH, AND PROOF OF ADDRESS**

- **IN PERSON AT UNITED METHODIST OPEN DOOR, 2130 E 21<sup>ST</sup> ST NORTH, WICHITA, KS**
- **BY EMAIL: CALL FOR EMAIL ADDRESS**
- **FAX: 316-267-8590**
- **MAIL:**  
**CSFP – SENIOR COMMODITIES**  
**P.O BOX 2756**  
**WICHITA, KS 67201**

In accordance with Federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, and 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, audio tape, 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 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.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, 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](mailto:program.intake@usda.gov).

#### OTHER HELPFUL PROGRAMS AND SERVICES

**Food Assistance (SNAP):** The Food Assistance Program (formerly known as the Food Stamp Program) helps people with little or no income. For those who are eligible, it provides benefits to buy nutritious food, even vegetable plants and seeds. For questions or to receive a paper application, call 1-888-369-4777. You can also apply online at [www.dcf.ks.gov](http://www.dcf.ks.gov).

**Medicaid:** The Medicaid program in Kansas is called KanCare. KanCare offers health insurance coverage for children, pregnant women, families with children, elderly, and adults and children with disabilities. For questions or to receive a paper application call 1-800-792-4884. For more information or to apply online, visit the KanCare website at [www.applyforkancare.ks.gov](http://www.applyforkancare.ks.gov).

**Medicare Savings Program:** Kansas has 3 Medicare Savings Programs (MSP). MSP are programs that help people on Medicare save money if they have limited income and resources. An MSP can pay all or part of your Medicare Part A, Part B and Part D premiums, deductibles, and co-pays. For questions or to receive a paper application, call 1-800-792-4884. For more information or to apply online, visit the KanCare website at [www.applyforkancare.ks.gov](http://www.applyforkancare.ks.gov).

**Low Income Energy Assistance Program (LIEAP):** LIEAP is a Federally funded program that helps eligible households pay a portion of their home energy costs by providing a one-time per year benefit. The LIEAP application period begins in mid November and will continue until 5 pm on the last business day of March; contact DCF for exact dates. During the application period, you can apply online [www.dcf.ks.gov](http://www.dcf.ks.gov). For questions or to receive a paper application, call 1.888.369.4777.

**Supplemental Security Income (SSI):** SSI is a federal program that provides monthly payments to people who have limited income and few resources. SSI is for people who are 65 or older, or those of any age who are blind or have disabilities. For questions you can call 1-800-772-1213 or visit [www.ssa.gov](http://www.ssa.gov). To start an online application, visit [www.ssa.gov/benefits/ssi](http://www.ssa.gov/benefits/ssi). You can request an appointment with your local Social Security office to apply in person by calling 1-800-772-1213 or at [www.ssa.gov/benefits/ssi/start.html](http://www.ssa.gov/benefits/ssi/start.html).

**Kansas Department for Aging and Disability Services (KDADS):** KDADS administers long-term services and support programs throughout the state to assist older adults and people with disabilities. For information, call 1-800-432-3535.

**Kansas Aging and Disability Resource Center (ADRC):** ADRC provides information, advice, counseling and assistance; helps people to make informed decisions about their long-term services and supports; and helps people access public and private programs. The ADRC serves people with all levels of income. For more information, call 1-855-200-2372.

THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER.



**KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES  
COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)  
PARTICIPANT APPLICATION**

Is the applicant or any qualifying household member participating in CSFP at another site?

YES  NO

Improper use and receipt of the CSFP benefits as a result of dual participation or other **program violations may lead to a claim against the individual** to recover the value of the benefits and may lead to disqualification from the CSFP.

<b>NAME OF APPLICANT</b>	<b>DATE OF BIRTH</b>
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<b>ADDRESS</b>	<b>COUNTY</b>
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<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
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<b>TELEPHONE NUMBER</b>	<b>TOTAL NUMBER LIVING IN HOUSEHOLD</b>
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NAMES OF HOUSEHOLD MEMBERS	AGE	DATE OF BIRTH

For additional household members, use back of form.

<p><b>CHANGES MUST BE REPORTED</b></p> <p>Participants must report changes in household income or composition <b>within 10 days</b> after the change becomes known to the household.</p>	<p>Indicate the source and amount of current income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income would include commissions, strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.</p> <table border="1" style="width:100%"> <thead> <tr> <th style="width:45%">HOUSEHOLD INCOME</th> <th style="width:25%">AMOUNT</th> <th style="width:30%">HOW OFTEN RECEIVED</th> </tr> </thead> <tbody> <tr><td>Gross Salary, Wages</td><td> </td><td> </td></tr> <tr><td>Social Security</td><td> </td><td> </td></tr> <tr><td>Public Assistance (Welfare)</td><td> </td><td> </td></tr> <tr><td>Child Support (Alimony)</td><td> </td><td> </td></tr> <tr><td>Pensions/Retirement</td><td> </td><td> </td></tr> <tr><td>Self-Employment</td><td> </td><td> </td></tr> <tr><td>Unemployment</td><td> </td><td> </td></tr> <tr><td>Other Income</td><td> </td><td> </td></tr> <tr><td><b>Total Household Income</b></td><td> </td><td> </td></tr> </tbody> </table>	HOUSEHOLD INCOME	AMOUNT	HOW OFTEN RECEIVED	Gross Salary, Wages			Social Security			Public Assistance (Welfare)			Child Support (Alimony)			Pensions/Retirement			Self-Employment			Unemployment			Other Income			<b>Total Household Income</b>		
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**RACIAL ETHNIC DATA (OPTIONAL) Mark your race? (Select one or more)**

<b>Are you of Hispanic or Latino origin?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>American Indian or Alaska Native</b>	<b>Asian</b>	<b>Black or African American</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>White</b>

**NAME OF APPLICANT**

**BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:**

- ✓ Standards for participation in the program are the same for everyone regardless of race, color, national origin, sex, age, and disability, or reprisal or retaliation for prior civil rights activity in any program, or activity conducted, or funded by USDA.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the program. Local agency will provide notification of a decision to deny or terminate CSFP benefits.
- ✓ You will be given nutrition, health, and social services referral information and are encouraged to seek needed assistance.
- ✓ You must report changes in household income or composition within 10 days after the change becomes known to the household.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.
- ✓ I am aware that deliberate misrepresentation may subject me to prosecution under applicable state and federal statutes.
- ✓ I am aware that I may not receive CSFP benefits at more than one CSFP site at the same time.
- ✓ I am aware that the information provided may be shared with other organizations to detect and prevent dual participation.

This application is being completed in connection with the receipt of federal assistance. Program officials may verify information on this form. 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 OR GUARDIAN ▶	DATE
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UPDATE INFORMATION, SIGN AND DATE FOR CERTIFICATION AFTER ON WAITING LIST ▶	DATE
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**FOR CERTIFYING AGENCY USE ONLY**

<input type="checkbox"/> IDENTITY/AGE VERIFIED-DESCRIBE PROOF PROVIDED	<input type="checkbox"/> RESIDENCY VERIFIED-DESCRIBE PROOF PROVIDED	<input type="checkbox"/> INCOME ELIGIBLE
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<input type="checkbox"/> KDADS, SNAP, LIEAP INFO GIVEN	APPLICANT ELIGIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CASELOAD AVAILABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
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WRITTEN NOTICE GIVEN <input type="checkbox"/> NOTICE OF CERTIFICATION STATUS <input type="checkbox"/> NOTICE OF ADVERSE ACTION	DATE OF WRITTEN NOTICE
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<input type="checkbox"/> ADDED TO WAIT LIST-DATE	DATE CERTIFIED
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SIGNATURE AND TITLE OF CERTIFYING OFFICIAL
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**PERIOD OF CERTIFICATION**

BEGINNING MONTH/YEAR	ENDING MONTH/YEAR
DATE OF SECOND YEAR VERIFICATION (MONTH/YEAR)	DATE OF THIRD YEAR VERIFICATION (MONTH/YEAR)