

Commodity Supplemental Food Program (CSFP) Application

To be eligible for this program, you must be at least 60 years of age
and your household income must be at or below 130% of the Federal Poverty Income Guideline.

INSTRUCTIONS: Please complete the application in full to avoid delays in processing.

- Page 1: Complete all required questions, including: proof of age, identity, and RI residency, self-declared income and the number of individuals in your household.
- Page 2: Read program guidelines, check yes or no, and sign and date at the bottom.
- Page 3: Designate a proxy (optional).

RETURN COMPLETED APPLICATIONS TO YOUR SITE, OR TO: Federal Programs Mgr., RI Community Food Bank, 200 Niantic Ave. Providence, 02907; Fax: 401-942-2113. For questions or assistance, call: 230-1708.

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Physical Address: _____ Telephone #: _____

City: _____ Rhode Island Zip Code: _____ Date of Birth: _____

Mailing Address (if different): _____ City: _____ RI Zip Code: _____

To help us find the best location for you to pick up your box, please answer the following questions:

- If you live in **senior housing** please provide the **Housing Site Name and Address:**
- If you currently use a **food pantry** please provide the **Name of the program and Location:**

In general, how do you plan to pick up your box? (check all that apply):

Personal or friend/family vehicle Public transportation (bus, etc.) Walk

Eligibility & Documentation

1. Verification of Identity and Age: proof of **identity** and **age, as proven by:** _____

2. Verification of Household Members: **Report** the number of **household members:** _____

Monthly Household Income: \$ _____ I receive SNAP benefits: Yes No

The following optional questions will not affect your consideration for the program.

Please answer both question 1 and 2.

1. Are you Hispanic or Latino? Yes No
2. Please identify the most appropriate selection or selections. You may choose more than one.
 - Native American or Alaskan Native Asian Black or African American White
 - Native Hawaiian or Pacific Islander
3. What is your preferred language?
 - English Spanish Russian Portuguese Other: _____

For Internal Use Only

Reviewer Signature and Date: _____

Commodity Supplemental Food Program Participant Rights and Responsibilities

I agree to provide accurate information on this application including:

- 1) Proof of address, 2) Proof of Identity, 3) Proof of age, and 4) Household Information

I understand that:

1. The Commodity Supplemental Food Program is a federally funded senior nutrition program geared to assist seniors age 60 and over whose income is at or below 130% of the Federal Poverty Income Guidelines
2. Participants must be Rhode Island Residents.
3. Standards for participation in this program are the same for everyone regardless of race, color, national origin, age, sex, and disability.
4. Participants are required to formally recertify every three (3) years to verify eligibility status; as well as update changes to their information on an annual basis.
5. If participants do not collect their food box for three consecutive months they will be removed from the program but will be allowed to re-apply at any time.
6. Participants will be required to show proof of identity and will be required to sign for the box each month.
7. Participants will report changes to household income or composition within 10 days after the change becomes known to the household.
8. Boxes will be distributed as a whole and may not be broken down prior to distribution.
9. Improper use/receipt of 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 benefits and/or disqualification from CSFP.
10. The local agency will make nutrition education available to all participants, will encourage them to participate, and provide information on other nutrition, health, or assistance programs and make referrals as appropriate.
11. If a Participant is provided with notification of a decision to deny or terminate CSFP benefits, the participant may appeal any decision regarding eligibility, disqualification or termination through the Fair Hearing Process guaranteed by the Rhode Island Office of Healthy Aging.

Applicant Certification:

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 the 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 check mark in the appropriate box: Yes No

Signature of Applicant: _____ **Date:** _____

Approved Proxies for CSFP Pick-Up

Participants may approve one or more proxies to pick-up and sign for CSFP boxes. Proxies must present appropriate identification in order to pick-up the box.

I hereby give permission to the following person(s) listed below to pick-up CSFP boxes on my behalf. I understand that in giving permission to the person(s) identified, I am accepting responsibility for their actions. This authorization becomes effective when received by the CSFP State representatives (Rhode Island Community Food Bank or authorized Local Distribution Agency). I agree to notify the Food Bank or Local Distribution Agency immediately if I decide to make any changes to my designated proxies.

Signature of Applicant: _____

Date: _____

Proxy Name: _____

Phone Number: _____

Proxy Name: _____

Phone Number: _____

Proxy Name: _____

Phone Number: _____

Income Eligibility Table		
(Note: Proxies are not required to meet the income eligibility guidelines)		
Gross Income for All Members of the Family Unit		
February 12, 2020		
130% of Federal Poverty Income Guidelines		
Family Unit Size	Monthly Income	Annual Income
1	\$1,383	\$16,588
2	\$1,868	\$22,412
3	\$2,353	\$28,236
4	\$2,839	\$34,060
5	\$3,324	\$39,884
6	\$3,809	\$45,708

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, audiotope, 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:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, 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.

RETURN COMPLETED APPLICATIONS TO:

CSFP Coordinator
Rhode Island Community Food Bank
200 Niantic Avenue
Providence, RI 02907
401-230-1708
Fax: 401-942-2113
CSFP@rifoodbank.org

TO REQUEST A FAIR HEARING, CONTACT:

Rhode Island Office of Healthy Aging
Louis Pasteur Building #57
c/o Ana Rosario
25 Howard Ave.
Cranston RI, 02920
401-462-0566

**Commodity Supplemental Food Program (CSFP)
Written Notice of Beneficiary Rights**



RHODE ISLAND COMMUNITY
FOOD BANK

Name of Organization: **Rhode Island Community Food Bank**
 Contact Information for Program Staff: **Lindsay Sgambato**
401-230-1707
lsgambato@rifoodbank.org

Because this program is 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 that are offered by us, and any participation by you in these activities must be purely voluntary;
- We must separate in time or location any privately funded explicitly religious activities from activities supported with USDA direct assistance;
- If you object to the religious character of our organization, we must make reasonable efforts to identify and refer you to an alternate provider to which you have no objection. We cannot guarantee, however, that in every instance, an alternate provider will be available; and
- You may report violations of these protections (including denials of services or benefits) by an organization to the State agency (<http://www.fns.usda.gov/fdd/food-distribution-contacts>). The State agency will respond to the complaint and report the alleged violations to their respective USDA FNS Regional Office (<http://www.fns.usda.gov/fns-regional-offices>).

We must provide you with this written notice before you enroll in our program or receive services from the program, as required by 7 CFR part 16.

Sincerely,

Lindsay Sgambato

CSFP State Agency
 Rhode Island Office of Healthy Aging
 Louis Pasteur Building #57
 Ana Rosario
 25 Howard Avenue
 Cranston, RI 02920
 401-462-0566

You may be eligible for other public assistance programs, including but not limited to:

1. **The [Supplemental Security Income \(SSI\)](#) program.** This program pays benefits to disabled adults and [children](#) who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. Phone: Toll-free at **1-800-772-1213** (TTY **1-800-325-0778**). Online: www.ssa.gov/agency/contact/
2. **Medical assistance.** Medicare is our country's health insurance program for people age 65 or older. Phone: Toll-free at **1-800-772-1213** (TTY **1-800-325-0778**). Online: <https://www.medicare.gov/>
3. **Supplemental Nutrition Assistance Program (SNAP).** SNAP is a federal program that provides assistance for low-income individuals and families to purchase nutritious food. Individuals and families qualify for SNAP benefits based on their income (less than 185% of the Federal Poverty Level). Phone: Toll-free at **1-855- 697-434**. Online: www.dhs.ri.gov/Programs/SNAPApplyNow.php