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: CSFP Coordinators, 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 <u>optional</u> 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 6, 2024 130% of Federal Poverty Income Guidelines		
Family Unit Size	**Monthly Income**	**Annual Income**
1	$1,632	$19,578
2	$2,215	$26,572
3	$2,798	$33,566
4	$3,380	$40,560
5	$3,963	$47,554
6	$4,546	$54,548

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 AD3027, 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

This institution is an equal opportunity provider.

RETURN COMPLETED APPLICATIONS TO:	**TO REQUEST A FAIR HEARING, CONTACT:**
CSFP Coordinator Rhode Island Community Food Bank 200 Niantic Avenue Providence, RI 02907 401-230-1708 Fax: 401-942-2113 CSFP@rifoodbank.org	Rhode Island Office of Healthy Aging Louis Pasteur Building #57 c/o Ana Rosario 25 Howard Ave. 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- 697-4347**. Online: www.dhs.ri.gov/Programs/SNAPApplyNow.php