PARTICIPANT APPLICATION

Household Information: To be completed by the applicant or authorized representative

Applicant Name (Last, First, Middle Initial):	**Phone Number**:	**Application Date**:

Street Address (Include Apt # if applicable):	**City**:	**Zip:**	**State**:	**County**:

Date of Birth (MM/DD/YY):	**Current Age**:

Total Household Gross Income (before deductions):
$_____

☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every 2 Weeks ☐ Weekly ☐ No Income

Household Size (Total number of household members, including applicant):

Eligibility requirement:
☐ In accordance with Executive Order 14218 of February 19, 2025, I certify that I am a U.S. citizen or "qualified alien" as defined under 8 U.S.C.1641. Illegal or ineligible aliens are not permitted to receive CSFP benefits.

Participate in one of the below Programs:

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Supplemental Security Income (SSI)
☐ Low Income Subsidy (LIS)
☐ Medicare Savings Programs (MSPs)

CSFP Income Guidelines 2026 (150% of poverty rate)

I hereby certify that my household income is at or below the following guidelines. ☐ Yes ☐ No

Household Size	Annual Income	Monthly Income	Twice Per Month	Every Two Weeks	Weekly Income
1	$23,940	$1,995	$998	$921	$461
2	$32,460	$2,705	$1,353	$1,248	$625
3	$40,980	$3,415	$1,708	$1,576	$789
4	$49,500	$4,125	$2,063	$1,904	$952
5	$58,020	$4,835	$2,418	$2,232	$1,116
6	$66,540	$5,545	$2,773	$2,559	$1,280
7	$75,060	$6,255	$3,128	$2,887	$1,444
8	$83,580	$6,965	$3,483	$3,215	$1,608
For each additional HH member, add:	$8,520	$710	$355	$328	$164

Ethnic/Racial Data: Optional - Data will not affect consideration of application for assistance. This information is requested solely to ensure compliance with Federal Civil Rights laws.

Ethnic Category (Select one):
Are you Hispanic or Latino?
☐ Yes ☐ No

Racial Category (Select one or more):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Proxy Information: A proxy is a person the applicant may authorize to pick up the CSFP food packages on their behalf for a specified time period. The proxy must be at least 18 years of age and must bring proof of his/her identification to pick up the CSFP food package. If you would like to designate a proxy, please complete the information below.

Name of Proxy (Must be at least 18 years of age):	**Designated Time Period for CSFP Food Pick Up** (Month/year):

OFFICIAL USE (Local Agency Staff Only)

Eligibility Criteria: ☐ Age ☐ Income ☐ County of Residence Applicant's Identification was Confirmed ☐

Verification Source(s) for Identification, Age and County of Residence: ☐ Driver's License ☐ State-Issued ID ☐ Other _____

Document Name (If other): _____

Local Agency Staff's Printed Name: _____

Local Agency Staff's Signature _____ Date: _____

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OFFICAL USE (To be completed by SUBRECIPIENT Official Only)		
Status: ☐ Eligible (Active List) ☐ Eligible (Waiting List)	**Method of Notification:** ☐ Verbal ☐ Letter	**Date of Notification:**
Initial Certification Period: From _____ to _____	**Re-Certification Period:** 1. From _____ to _____ 2. From _____ to _____	**Re-Certification Dates of Notification** 1. _____ 2. _____
If applicable: Date Certified as Active from Wait List:		
Status: ☐ Ineligible ☐ Discontinued ☐ Disqualified ☐ Terminated	**Date of Written Notification:**	
Ineligible/Discontinued/Disqualified/Terminated-Reason:		
SUBRECIPIENT Official's Name (Print): _____ **Title:** _____ **SUBRECIPIENT Official's Signature:** _____ **Determination Date:** _____		

"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, 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov"

This institution is an equal opportunity provider

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 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/Authorized Representative (Circle One): **Date:**

APPLICATION INSTRUCTIONS: Complete application in black or blue ink only.

To Be Completed by the Applicant or Authorized Representative

Applicant Name	List applicant's last name, first name and middle initial.
Telephone Number	List applicant's area code and telephone number.
Application Date:	List the date of application.
Street Address	List applicant's street address and if applicable, apartment number.
City	List applicant's city of residence.
Zip Code	List applicant's zip code.
County	List the applicant's county of residence.
Date of Birth	List applicant's month, day and year of birth.
Current Age	List applicant's age.
Total Household Gross Income and How Often is Received	List the total household gross income (before deductions) and check the box for how often income is received (i.e., weekly, monthly, etc.). If no one in the household receives income, check the No Income box.
Participates in one of the Below Programs	Indicate if the applicant is currently enrolled in one of the listed federal or state level programs.
Household Size	List the total number of household members, including applicant.
Income Certification	Check either Yes or No to certify the household income is within the allowable guideline limits.
Ethnic & Racial Data	This question is optional for the applicant. Please select one Ethnicity, then select one or more Race categories.
Proxy	Complete only if authorizing an individual to pick up the CSFP food kit on the applicant's behalf. Provide the proxy's name and the time period in which the applicant designates the individual as a proxy.
Certification Statement	Read the certification statement and check either Yes or No.
Signature of Applicant/Authorized Representative	The person for whom CSFP benefits are being requested must sign the application. If the application is being made by an authorized representative, the authorized representative may sign on behalf of the applicant.
Signature Date	List the date the application is signed.

Official Use - To Be Completed by Local Agency Staff Only

Eligibility Criteria/ Applicant Identification	Once the applicant's eligibility criteria and identification have been verified/confirmed, check all applicable boxes. If any box cannot be checked as applicable, the applicant is not eligible for participation.
Verification Source(s)	Check the applicable box(s) for the verification source(s) used to verify/confirm the applicant's identification, age, and county of residence (i.e., driver's license, State-issued ID, etc.). If Other is checked, list the document name (i.e., passport, birth certificate, Medicare Card, etc.). A Social Security card is not an acceptable source of verification.
Local Agency Staff Printed Name	Print the name of the designated Local Agency staff verifying the information on the application.
Local Agency Staff Signature/Date	Provide the signature of the designated Local Agency staff and date the application is received or taken.

Official Use - To Be Completed by Subrecipient Official Only

Status	Indicate the application determination status (i.e., eligible, ineligible, etc.).
Method of Notification/Date	Check appropriate box and list the date of initial notification.
Date Certified as Active from Waiting List	List the date the applicant was certified as Active from the Waiting list.
Re-Certification Period/Date	List the re-certification period and the date the applicant was notified of re-certification.
Waiting List Notification	List the date the applicant was notified that he/she was being placed on a waiting list.
Ineligible/Terminated reason/Date	If an applicant is ineligible or if a participant is discontinued, disqualified or terminated, provide the reason and the date of the written notification.
SUBRECIPIENT Official's Printed Name/Title	Print Name and title of SUBRECIPIENT Official.
SUBRECIPIENT Official's Signature	Signature of SUBRECIPIENT Official making eligibility determination.
Determination Date	List the date the eligibility/ineligibility determination was made.