Commodity Supplemental Food Program (CSFP)

Recertification (due annually)

Please Check One:	**ALL APPLICANTS PLEASE PROVIDE DATE OF BIRTH**

Elder: (60 or Older): **Date of Birth**_____

You must be 60 years or older and meet income guidelines to qualify for this program. The income levels change each year. Check the Vermont Foodbank web-site for the current guidelines.

LAST Name:_____ **FIRST**_____ **MI**:_____

MAILING Address: _____**Apartment Number**: _____

City: _____State: **VT.** **Zip Code**: _____

Senior Housing Name: _____ _____

Town of Residence: _____**Telephone number:**_____(required)
(**MUST:** have this- may differ from mailing address)
Name of Parent or Legal Guardian: _____

TOTAL MONTHLY Household Income: $_____**Number of People in household**:_____

DO YOU PRESENTLY RECEIVE 3SQUARESVT (FORMERLY) FOOD STAMPS? YES NO (Check one)

PROXY UPDATE
If you need to ***CHANGE*** your proxy (person that picks up food box in your place) you must complete information below. The proxy must present appropriate identification at time of food box pick up.
If there is no change in Proxy, proceed to back page for signature.

Person, Organization or Senior Housing Site authorized to pick up/accept delivery of food.

Individual OR Organization: _____
If Organization, Contact Person Name: _____

Address:_____

City: _____Zip Code:_____

PROXY: Telephone number: _____

YOUR RIGHTS AND RESPONSIBILITIES IN THE VERMONT CSFP

I AGREE TO PROVIDE:

*Proof of my income, address, age and identification if requested

*Correct information about my current household and income

***NOTE*: Any change in my address, income, telephone number or household composition within ten (10) days after the change becomes known to the household (Required)**

SIGNATURE REQUIRED ON BACK OF FORM

I UNDERSTAND THAT:

- Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- CSFP will provide a box of supplemental foods each month at a predetermined delivery site
- CSFP will provide referrals to nutrition, health, or assistance programs as appropriate
- CSFP will provide written nutrition education to all program participants.
- If I do not pick up food three (3) months in a row, without telling staff, I will be taken off of the program.
- I will be dropped from this program if I participate in another CSFP or WIC program
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits, and may lead to disqualification from CSFP.
- I may appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.

CERTIFICATION

This re-application form 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 both CSFP and WIC benefits simultaneously, and 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**

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:
By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete to the best of my knowledge.

Signature of Applicant/Guardian:_____ Date:_____

Mail or fax completed form to:

The Vermont Foodbank
Commodity Supplemental Food Program
33 Parker Road
Barre, Vermont 05641

Fax: 1-802-476-3326

Questions: 1-800-214-4648

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