Vermont Foodbank
vtfoodbank.org

Contact the CSFP Team
csfp@vtfoodbank.org
1-800-214-4648

# Commodity Supplemental Food Program (CSFP) Recertification Form

This form must be completed annually. You must be 60 years or older and meet income guidelines to qualify for this program. Income levels change each year. Please visit vtfoodbank.org/csfp for the current guidelines.

**Name** *(Required)*

Last: _____ First: _____

**Contact Information**

Telephone *(Required)*: _____ Email: _____

**Physical Address** *(Required)*

Street Address: _____

Address Line 2: _____ City: _____ State: **VT** Zipcode: _____

**Mailing Address** *(Required)*

Street Address: _____

Address Line 2: _____ City: _____ State: **VT** Zipcode: _____

Housing Site Name *(Not Your Name)* Where You Live If Applicable: _____

**Income & Household Information**

*Please visit vtfoodbank.org/csfp for current income and household size guidelines.*

Monthly Total of **All** Household Incomes: $ _____

Number of Household members: _____

Do You Recieve 3SquaresVT (Formerly Foodstamp)? ☐ Yes ☐ No

*You can recieve both CSFP and 3SquaresVT at the same time.*

**Age Verification** *(Required)*

*You must be 60 years of age or older to participate in the Commodity Supplemental Food Program.*

Date of Birth: _____

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.**

**1. Individual or Organization**

Name: _____

Organization Name (if applicable): _____

Street Address: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

# YOUR RIGHTS AND RESPONSIBILITIES IN THE VERMONT CSFP

## I AGREE TO PROVIDE:

- Proof of my income, address, and identification if requested
- Correct information about my current household and income
- **Any change** in my address, telephone number, income, or household composition **within ten (10) days** after the change becomes known to the household.

## 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, 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 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 ANDWHAT 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: _____ Date: _____

**Mail or Fax This Completed Form To:**

Vermont Foodbank
Commodity Supplemental Food Program
33 Parker Rd.
Barre, VT 05641
Fax: 802-476-3326

**Questions? Contact Vermont Foodank at:**

Phone: 800-214-4648

Email: csfp@vtfoodbank.org

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