Vermont Foodbank

Questions? Contact Vermont Foodbank at:
Phone: 800-214-4648
Fax: 802-476-3326
Email: csfp@vtfoodbank.org

Commodity Supplemental Food Program (CSFP) Recertification

This form must be completed annually. You must be 60 years old or older and meet income guidelines to participate in CSFP. Income guidelines change annually—visit vtfoodbank.org/csfp for current guidelines. Be sure to accurately report your **date of birth** and **gross monthly income** in this recertification. **Please note: bolded fields are required.**

1. Applicant Information

Last Name: _____ **First Name:** _____

Date of Birth: ____/____/_____ (You must be 60 years of age or older to participate in CSFP.)

2. Contact Information

Mailing Address: _____ **Apt. #:** _____
City: _____ **State:** _____ **Zip Code:** _____
☐ Physical address is same as mailing address

Physical Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
☐ I do not have a physical address

Phone Number: _____
Can you receive text messages? ◯ Yes ◯ No

Email Address:
_____

3. Income & Household Information

A household is people you purchase/prepare food with. **Number of people in your household:** _____

Total gross income: all forms of income from all household members before taxes, Medicare, insurance premiums, and any other deductions are taken out. Note: SNAP benefits do not count as income.
Total household gross monthly income: _____

Do you receive 3SquaresVT/SNAP food benefits? ◯ Yes ◯ No

4. Proxy Change

If you need to CHANGE or ADD a new proxy, you must complete this section.

Proxy Name: _____
Organization (if applicable):
_____
Phone Number: _____

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_____
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Rights and Responsibilities:

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 10 days after the change becomes known to the household.

I understand that:

- If I do not pick up food two (2) months in a row, I will be taken off the program.
- 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 monthly box of supplemental food 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.
- I will be dropped from this program if I participate in another CSFP program.
- Improper use or receipt of CSFP benefits because 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.

5. Certification

This 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.

◯ **Yes** ◯ **No**

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.

◯ **Yes** ◯ **No** **Signature:** _____ **Date:** _____

6. Signature

I attest that the date of birth and the income reported in this application are accurate. I have read the Rights and Responsibilities and attest that all information in this application is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

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In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410
   Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Mail, fax, or email this completed form to:

1. Mail: Vermont Foodbank CSFP
   33 Parker Road
   Barre, VT 05641
2. Fax: 802-476-3326
3. Email: csfp@vtfoodbank.org

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You may be eligible for these resources:

- **3SQUARESVT (also known as SNAP/EBT/Foodstamps):** Money to buy groceries. Our Vermont Foodbank team can offer information and enrollment assistance 1-855-855-6181.
- **MEDICAID:** Free or low-cost healthcare. To learn more contact the Department of Vermont Health
  Access 1-855-899-9600.
- **SENIOR FARMERS MARKET COUPONS:** Free fruit/veggie coupons for local farmers markets or farmstands. Applications open each July at your local Community Action Agency 1-800-642-5119 (VT helpline).
- **VT AREA AGENCIES ON AGING:** Information and support to adults 60+ and their families. Call the helpline 1-800-642-5119 to be connected with your regional agency.
- **SUPPLEMENTAL SECURITY INCOME (SSI):** Monthly payments to older adults with limited resources. Call the helpline 1-800-642-5119 to connect with support.