State of Hawaii
Commodity Supplemental Food Program (CSFP)
Participant Application Form

Last Name:_____ First Name:_____ Gender: ☐ Male ☐Female

Address:_____ Apt #:_____ City:_____ Zip:_____

ID#:_____ Date of Birth:_____ Age:_____ Phone #:_____

Primary Language: ☐ English ☐Tagalog ☐ Mandarin ☐Cantonese ☐Japanese ☐Korean ☐Vietnamese ☐Laotian ☐Other _____

Racial and/or ethnic data collected on this form has no effect on the eligibility determination of the household
Are you Hispanic or Latino? ☐**Yes or** ☐**No**

RACIAL/ETHNIC PARTICIPATION DATA
What is your race? (Circle all that apply)

A = Asian W = White B = Black or African	H = Native Hawaiian or Other Pacific Islander
I = American Indian or Alaska Native	

MONTHLY HOUSEHOLD INCOME LIMITS:
$1,502 for a one-person household; $2022 for two

Monthly Household Income $

How many persons are supported by this income?

1 Person 2 Person Other

Source of Income, Check all that apply: No Income Disability

Pension Social Security SSI Wages Unemployment

PROXY

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUALS TO ACT AS MY AUTHORIZED REPRESENTATIVE FOR CSFP:

Last Name:_____ First Name:_____ Phone#:_____

Last Name:_____ First Name:_____ Phone#:_____

Last Name:_____ First Name:_____ Phone#:_____

Alternate Mailing Address: ***(If you have someone else receive your mail such as care taker, family member, or power of attorney)***

Last Name:_____ First Name:_____ Phone#:_____

Address: Apt #: City: Zip:

OFFICE USE ONLY

ENROLLMENT ID #_____ **ENROLLMENT DATE:** _____

SITE NAME:_____ **SITE#:** _____

CSFP PARTNER AGENCY: _____

☐ **TRANSFER CLIENT FROM:** _____

New Enrollment Recertification Ineligible Waiting List Date:

Re-certification period: From: _____ **to:** _____ **Date placed on waiting list:** _____

Method of notification: Verbal Telephone Letter

PLEASE CHECK BOXES FOR UNDERSTANDING

- ☐ **Enrollment**. You will be enrolled for 6 months at a time. You must recertify every 6 months. You must continue to meet all eligibility requirements during the time you are enrolled.

- ☐ **I Agree** to inform the (*insert local agency's name*) in writing within 10 days of any changes in my contact information.

- ☐ **Commodity Pick up**. You may actively participate at only **ONE distribution site**. You may request a site change **ONCE** with a written request. If you **do not pick up** a food box for three **(3) months in a row** you will become **ineligible** for the program.

- ☐ **CSFP** recipients who are removed from the program for being "inactive participants" are allowed to re- apply for benefits by filling out another CSFP application. If a waiting list exists, however, I understand my application will go on the list according to the date it was received.

- ☐ **I CANNOT** trade/sell CSFP food or purchase/use someone else's CSFP food for my household.

- ☐ **Termination**. You will be notified in writing of termination and have the right to a fair hearing.

- ☐ **Fair Hearing.** If you are found ineligible for this program during a recertification review, you have the right to a fair hearing in accordance with the provisions of Federal and State law.

- ☐ In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

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 both CSFP and WIC benefits simultaneously 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. **YES NO**

APPLICANTS MAY SELF–DECLARE ELIGIBILITY BY SIGNING THIS APPLICATION

_____	_____	_____
Print Name of Participant	**Signature of Participant**	**Date**

xh

CSFP food boxes are packaged and delivered by the (*insert local agency's name*) (*insert local agency's address*)
If you have questions please call (*insert local agency's CSFP contact person's name and contact information*).