Wyoming CSFP

Commodity Supplemental Food Program Application

Mail completed application to: Wyoming Food Bank of the Rockies
P.O. Box 1540, Evansville, WY 82636

NAME OF APPLICANT	TELEPHONE NUMBER	COUNTY

PHYSICAL ADDRESS (Street, City, Zip Code)

MAILING ADDRESS (if different) (Street, City, Zip Code)

APPLICANT'S DATE OF BIRTH	Total No. Living in Household

NAMES OF QUALIFYING HOUSEHOLD MEMBERS	AGE	DATE OF BIRTH

CHANGES MUST BE REPORTED:

Participants must report changes in household income or composition **within 10 days** after the change becomes known to the household.

Indicate the source and amount of current (last month's) income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income would include commissions; strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.

HOUSEHOLD INCOME	AMOUNT	HOW OFTEN RECEIVED
GROSS SALARY, WAGES		
SOCIAL SECURITY		
PUBLIC ASSISTANCE		
CHILD SUPPORT (ALIMONY)		
PENSIONS/RETIREMENT		
SELF-EMPLOYMENT		
UNEMPLOYMENT		
OTHER INCOME		
TOTAL HOUSEHOLD INCOME		

2/11/2020 – 1/31/2021 Income Eligibility Guidelines

Household Size	Senior (Maximum Monthly Household Income)	Senior (Maximum Annual Household Income)
1	$1,383	$16,588
2	$1,868	$22,412
3	$2,353	$28,236
4	$2,839	$34,060
5	$3,324	$39,884
6	$3,809	$45,708
7	$4,295	$51,532
8	$4,780	$57,356
For each additional family member, add	$486	$5,824

RACIAL ETHNIC DATA (OPTIONAL)

Are you of Hispanic or Latino origin? (For statistical purposes only) ☐ **YES** ☐ **NO**

What is your race? (Select one or more)	AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC	WHITE

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the Program.
- ✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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; and improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me to recover the value of the benefits and may lead to disqualification from CSFP. 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	DATE
SIGNATURE OF PROXY	DATE
Applicant Signature for Certification from Waiting List	DATE

* FOR CERTIFYING AGENCY USE ONLY *			
The following have been verified: ☐ Identity ☐ RESIDENCY ☐ Age ☐ Household members	APPLICANT ELIGIBLE? ☐ Y ☐ N	CASELOAD AVAILAB	DATE WRITTEN NOTICE GIVEN:
CERTIFYING OFFICIAL SIGNATURE	DATE CERTIFIED		PERIOD OF CERTIFICATION 1st Mo: Last Mo:

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, disability, age, 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: https://www.ascr.usda.gov/filing-discrimination-complaint-usda-customer, 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.

SENIOR PARTICIPANT EXTENSION OF CERTIFICATION PERIOD

NAME OF PARTICIPANT	TELEPHONE NUMBER	
ADDRESS	CITY/ZIP CODE	COUNTY
NAMES OF QUALIFYING HOUSEHOLD MEMBERS	AGE	

*** * * * * * * * * * * * FOR RECERTIFICATION USE ONLY * * * * * * * * * * ***

- Participants address and continued interest in receiving CSFP benefits has been verified.
- Local agency has sufficient reason to believe participant (s) still meets the income eligibility standards (e.g. the senior person has a fixed income)
- Local agency has notified participant verbally or in writing of the period of the extension.

CERTIFYING OFFICIAL SIGNATURE	Date Certified	Certification Period 1st Month: Last Month:
APPLICANT SIGNATURE	Date	
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APPLICANT SIGNATURE	Date	

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