

CSFP Applicant Self-Declaration of Need Form 302002: WRITE-IN



| | | | |
|--|--------------|---------------------------|---|
| Name of Participant: | | Must Provide Proof | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| | | Date of Birth: | <input type="checkbox"/> Prefer not to say. |
| Street Address: | Apt#: | City: | Zip: |
| Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home | | Email address: | |

What is your total household income? \$ _____ **How many persons live in your household? _____**

Household Income Reported is Received [Check One]: Weekly Monthly Annually

| 2021-22 CSFP Income Guidelines – Elderly 130% of Poverty | | | |
|--|----------|---------|---------|
| Household Size | Annual | Monthly | Weekly |
| 1 | \$16,744 | \$1,396 | \$322 |
| 2 | \$22,646 | \$1,888 | \$436 |
| 3 | \$28,548 | \$2,379 | \$549 |
| 4 | \$34,450 | \$2,871 | \$663 |
| 5 | \$40,352 | \$3,363 | \$776 |
| 6 | \$46,254 | \$3,855 | \$890 |
| 7 | \$52,156 | \$4,347 | \$1,003 |
| 8 | \$58,058 | \$4,839 | \$1,117 |
| For each additional household member, add: | \$5,902 | \$492 | \$114 |

| Household Member | First Name | Last Name | Birthdate | Gender [Circle One] |
|------------------|------------|-----------|-----------|------------------------|
| 2 | | | | Male or Female |
| 3 | | | | Male or Female |
| 4 | | | | Male or Female |

For additional household members turn over.

Are you Hispanic or Latino? [Check Only One] Yes No

What is your race? [Check All That Apply] American Indian or Alaska Native Asian White

Black or African American Native Hawaiian or Another Pacific Islander

"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. 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 Participant / Caretaker [Check One]:

Print Name of Caretaker:

| | | |
|------------------------------|---------------------------|--------------|
| Proxy 1 – Print Name: | Proxy 1 Signature: | Date: |
| Proxy 2 – Print Name: | Proxy 2 Signature: | Date: |

| | |
|---------------------------------------|----------------|
| Site Name: | County: |
| Site Representative Signature: | Date: |

USDA Non-Discrimination Statement is on the back. Please turn over.

| Household Member | First Name | Last Name | Birthdate | Gender Circle One |
|------------------|------------|-----------|-----------|-------------------|
| 5 | | | | Male or Female |
| 6 | | | | Male or Female |
| 7 | | | | Male or Female |
| 8 | | | | Male or Female |

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: [How to File a 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
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.