

# Elderly CSFP Application

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (City) (Zip) (County)

Soc. Security No. \_\_\_\_\_ Phone: \_\_\_\_\_ No. in Household \_\_\_\_\_

Qualifying Household Members: Age: Date of Birth: Category:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Race: \_\_Black \_\_White \_\_American Indian/Alaskan Native \_\_Hispanic \_\_Asian/Pacific Islander

## Household Income:

Indicate source and amount of current (last month's) income before deductions, such as taxes and Social Security. THIS AMOUNT MUST INCLUDE ALL INCOME OF ALL HOUSEHOLD MEMBERS. If last month's income is not representative, please project a yearly income which would be. "Other" income could be commissions, strike benefits, income from trusts, contributions from relatives, etc. Food Stamp benefits do not count as income.		Amount	How often received
	Social Security	_____	_____
	Public Assistance (Welfare)	_____	_____
	Pension/Retirement	_____	_____
	Self-Employment	_____	_____
	Other (Specify)	_____	_____
	Total Household Income:	_____	

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice & TDD). USDA is an equal opportunity provider and employer.

I understand it is illegal to participate in the CSFP in more than one local agency, or to participate simultaneously in the CSFP and in the WIC program.

This certification 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 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.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

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

Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

New Certification:            Eligible: \_\_\_\_\_    Not Eligible: \_\_\_\_\_

Certification date from: \_\_\_\_\_ to \_\_\_\_\_

Title of Certifier \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2nd Certification:            Eligible: \_\_\_\_\_    Not Eligible: \_\_\_\_\_

Certification date from: \_\_\_\_\_ to \_\_\_\_\_

Title of Certifier \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Contact by Phone: \_\_\_\_\_ In Person \_\_\_\_\_

Client wishes to remain on CSFP for a consecutive six months? \_\_\_\_\_

Client Address Changed? \_\_\_\_\_ If YES, New Address: \_\_\_\_\_

\_\_\_\_\_  
If ineligible please state reason: \_\_\_\_\_

\_\_\_\_\_  
*You may appeal any decision made by the local agency regarding your denial or termination from the program.*

*If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.*