

Nebraska CSFP Certification Form

Local Agency _____

Clinic Site _____

TO BE COMPLETED BY APPLICANT **PLEASE PRINT**

Date _____ Responsible Party _____
LAST FIRST MIDDLE

Name of Applicant _____
LAST FIRST MIDDLE

Address _____
STREET ADDRESS OR BOX NUMBER CITY COUNTY STATE ZIP CODE

Telephone No. (_____) _____ Date of Birth _____ Sex: Male Female
Area Code Month Day Year

Race/Ethnic Code _____ Handicap _____ Are you currently a migrant farmworker? Yes No

Household Income \$ _____ How many persons are supported by this income? _____ Have you ever been on the Commodity Program (CSFP)? Yes No
 Weekly Monthly Yearly If yes, where? _____

Have you ever been on the WIC Program? Yes No Date applicant last received vouchers from WIC or food from CSFP _____
 Is yes, where? _____ Do you have a WIC or CSFP I.D. card? Yes No

TO BE COMPLETED BY PROGRAM STAFF New Recertification

First visit to apply for program (this certification) _____ Date certified/denied _____ Date food first issued (this certification) _____ Date eligibility data taken _____	CATEGORY <input type="checkbox"/> Infant <input type="checkbox"/> Elderly <input type="checkbox"/> Child <input type="checkbox"/> Home Delivery (Elderly Only) <input type="checkbox"/> Pregnant Estimated Delivery Date: _____ <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Post Partum, Non-Breastfeeding Actual Delivery Date _____	Income Eligibility: <input type="checkbox"/> Eligible: _____ Verification _____ Categorical Eligibility: <input type="checkbox"/> Eligible: _____ Verification _____ Residence Eligibility: <input type="checkbox"/> Eligible: _____ Verification _____	Determined: <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible <input type="checkbox"/> Waiting List Even No Recertification ELDERLY ONLY Date of contact: _____ <input type="checkbox"/> Continue for 6 mo <input type="checkbox"/> Term not interested
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Referrals: <input type="checkbox"/> Food Stamps <input type="checkbox"/> Dept. of Social Services <input type="checkbox"/> Head Start <input type="checkbox"/> Family Planning <input type="checkbox"/> Other: _____	ELDERLY Homebound Criteria: <input type="checkbox"/> No Transportation <input type="checkbox"/> Physical Disabilities _____ <input type="checkbox"/> Other: _____ Further Explanation _____	Priority _____ Expiration Date _____ I hereby certify that this assessment was made on the basis of information contained within the files of our agency. All eligibility criteria were applied as defined by the Nebraska Department of Health. Signature _____ Title _____
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PARTICIPANT AGREEMENT

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. Program benefits are provided in connection with the receipt of Federal assistance.
3. Program officials may verify information on this form.
4. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
5. I may appeal any decision made by the local agency regarding my eligibility for the Program. A request for a fair hearing can be submitted to the local agency.
6. The local agency will make health services and nutrition education available to me and I am encouraged to participate in these services.
7. I understand that participating in the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP) at the same time or participating in more than one WIC or CSFP program at the same time is not allowed and will result in being removed from at least one Program.
8. I have been advised on my rights and obligations under the Program.
9. If placed on the Program: I will pick up Food as directed. Failure to pick up food as directed will result in being dropped from the Program.
10. I understand that the foods provided by this Program are intended for the participant for whom they are prescribed.
11. I understand CSFP is a supplemental rather than total food program.
12. I consent to the release of information CSFP staff which includes students in health-related fields observing in the clinic, to my physicians, to another WIC/CSFP agency if I wish to transfer, and to the officials of USDA, Department of Health and Human Services (CDC), and of the Nebraska Department of Health.

REQUESTING A FAIR HEARING

If I am dissatisfied with any decisions made regarding the eligibility or receipt of benefits, the following procedure may be followed:

1. I may talk with the CSFP workers at this clinic, contact the local CSFP Program Director, or the MCH/Nutrition Division, Nebraska Department of Health, to have my case reviewed.
2. If I am not satisfied with the explanation of the workers or the Local Program Director, I may request a fair hearing by mail, verbally, or present a written request in person to the Local Program Director. My request should be made within 60 calendar days from the date the Local Agency mailed or gave me the written notice of denial or termination of benefits.
3. I will be contacted by the Fair Hearing Officer or his/her designated representative within a week after my written request is received. At this time a date will be set for the hearing. I will be notified at least 10 calendar days before the hearing. The hearing will be held within 21 calendar days of receipt of the request for a fair hearing.
4. I may present my position personally or select a representative to do so. If my representative or I cannot appear at the scheduled time and place, I may request the hearing officer to change it. I will be provided one opportunity to reschedule the hearing date upon written request submitted to the Nebraska Department of Health.
5. If my representative or I do not appear for the hearing or if I request the hearing to be cancelled, it will be cancelled.
6. The Local Program Director and I will be sent a written decision concerning the hearing within 45 calendar days after the hearing was requested.
7. The CSF Program must follow that decision. I must follow the decision made also.
8. If I do not agree with the decision made at the local hearing, I may ask for an appeal by contacting the Fair Hearing Officer of the State Agency as Follows: State Health Officer, Nebraska Department of Health, 301 Centennial Mall South, P.O. Box 95007, Lincoln, Nebraska 68509.

If I desire an appeal, a request for a rehearing must be filed within 10 calendar days after the receipt of the fair hearing decision.

9. The detailed Fair Hearing Procedures are on file with the Local Program Director. A copy is available on request.

THIS IS AN EQUAL OPPORTUNITY PROGRAM, IF YOU BELIEVE YOU HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, AGE, SEX, OR HANDICAP, WRITE IMMEDIATELY TO THE SECRETARY OF AGRICULTURE, OR THE DIRECTOR, OFFICE OF ADVOCACY AND ENTERPRISE, WASHINGTON, D.C. 20250.

1st Period			
	SIGNATURE	RELATIONSHIP TO APPLICANT	DATE
2nd Period			
	SIGNATURE	RELATIONSHIP TO APPLICANT	DATE
3rd Period			
	SIGNATURE	RELATIONSHIP TO APPLICANT	DATE