NEBRASKA CSFP CERTIFICATION FORM

APPLICATION DATE:_____

AGENCY:

_____

CLINIC/DISTRIBUTION SITE:

_____

HOME DELIVERY ROUTE:

_____

If new to this agency:

Have you been on the Commodity Program (CSFP)? ☐ Yes ☐ No

If Yes, where? _____

Date last received food? _____

Name of Applicant_____
Last First MI

Responsible Party_____
Last First MI Relationship

Address _____
Street Address PO Box (if any)

_____
City County State Zip

(____) _____ DOB ____/____/____ SEX: ☐Male ☐ Female
Phone Receive VM or TEXT? Month Day Year

Age Verification	☐ Dr. Lic. ☐ Birth Cert. ☐ NE ID Card ☐ Other (specify):
Address Verification	

Race/Ethnic data collection:

What is your race? (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/other Pacific Islander
- ☐ White

Are you Hispanic/Latino?

☐ No ☐ Yes

SOURCE OF INCOME: (mark all that apply to you and anyone in your household)

	AMOUNT PER MONTH		AMOUNT PER MONTH
___SOCIAL SECURITY	$_____	___SSI	$_____
___SOC. SEC. DISABILITY	$_____	___WAGES	$_____
___ PRIVATE INS. DISABILITY	$_____	___INTEREST	$_____
___PENSION/RETIREMENT	$_____	___FARM/RENTAL (from tax return)	$_____
___VETERANS CHECKS (all count whether taxable or not)	$_____	___UNEMPLOYMENT	$_____

TOTAL SELF-DECLARED HOUSEHOLD INCOME: $_____ _____ # in household supported by this income

IF NONE, EXPLAIN HOW THEY ARE LIVING AND PAYING BILLS:

Determined:

- ☐ ELIGIBLE FOR FOOD _____ through _____
- ☐ NOT ELIGIBLE
- ☐ PLACED ON WATING LIST

DATE DETERMINED _____

DATE NOTIFIED_____

Notification form done by:
STAFF INITIALS _____

☐ WRITTEN FORM ☐ ON APPT. CARD

I hereby certify that this assessment was made based on the eligibility criteria as defined by the NE Dept. of Health and Human Services and approved by USDA-FNS.

_____ _____
Signature Title

These foods are intended for the use of the participant for whom they are prescribed.

I verify that I have received foods for the months stated by signature:

NOTES:

1._____ _____ 7._____ _____

2._____ _____ 8._____ _____

3._____ _____ 9._____ _____

4._____ _____ 10._____ _____

5._____ _____ 11._____ _____

6._____ _____ 12._____ _____

APPLICANT'S RIGHTS AND RESPONSIBILITIES

Failure to comply with the rules below may result in disqualification from participation in the Commodity Supplemental Food Program.

1. The local agency will provide notification of a decision to deny or terminate CSFP benefits, and of an individual's right to appeal this decision by requesting a fair hearing;
2. The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants, and will encourage them to participate;
3. The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate;
4. Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits, and may lead to disqualification from CSFP; and
5. Participants must report changes in household income or composition within 10 days after the change becomes known to the household.

CERTIFICATION STATEMENT

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, and 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

ONE of the boxes below **MUST** be checked for each certification period:

For the purpose of complying with Neb. Stat. §§4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States

OR

☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____, and I agree to provide a copy of my USCIS documentation.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

In the event that I or my responsible party is unable to pick up my commodity foods, I authorize the following as my proxy(s):

1)_____ 2)_____

☐ I do not wish to have a proxy. Participant signature_____

This form must be signed by the applicant. (If signed by a POA, agency must have a copy of the POA document)

_____ _____

Signature Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, it 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 on line 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. U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Ave., SW, Washington, D.C. or 2, Fax: (202) 690-7442 or 3: email: programintake@usda.gov

CSFP INFORMAL REVIEW #1

Applicant name_____ DATE OF CONTACT_____

Any changes in income, address, phone number or household composition?

Continued interest in staying on the program?

☐ Continued eligibility for CSFP from _____ to _____

☐ Term (not interested or no longer eligible) STAFF INITIALS

In the event that I or my responsible party is unable to pick up my commodity foods, I authorize the following as my proxy(s):

1)_____ 2)_____

☐ I do not wish to have a proxy.

Participant signature if changed from previous year._____

☐ No change from previous year. No signature necessary.

REFERRALS/NOTES:

These foods are intended for the use of the participant for whom they are prescribed.

I verify that I have received foods for the months stated by signature.

1._____ _____ 7._____ _____

2._____ _____ 8._____ _____

3._____ _____ 9._____ _____

4._____ _____ 10._____ _____

5._____ _____ 11._____ _____

6._____ _____ 12._____ _____

CSFP INFORMAL REVIEW #2

Applicant name_____ DATE OF CONTACT_____

Any changes in income, address, phone number or household composition?

Continued interest in staying on the program?

☐ Continued eligibility for CSFP from _____ to _____

☐ Term (not interested or no longer eligible) STAFF INITIALS ☐

In the event that I or my responsible party is unable to pick up my commodity foods, I authorize the following as my proxy(s):

1)_____ 2)_____

☐ I do not wish to have a proxy.

Participant signature if changed from previous year._____

☐ No change from previous year. No signature necessary.

REFERRALS/NOTES:

These foods are intended for the use of the participant for whom they are prescribed.

I verify that I have received foods for the months stated by signature.

1._____ _____ 7._____ _____

2._____ _____ 8._____ _____

3._____ _____ 9._____ _____

4._____ _____ 10._____ _____

5._____ _____ 11._____ _____

6._____ _____ 12._____ _____

RECERTIFICATION NOTICE GIVEN ON _____(date) by _____

☐ At clinic in person

☐ Verbally on phone Other:

☐ In delivery box