NEBRASKA CSFP CERTIFICATION FORM

CLINIC SITE _____

☐ BVCA ☐ LIC
☐ CNCS ☐ MID NE CAP
☐ GRHCA ☐ WESTERN NE CAP
☐ ENCAP ☐ WCHR

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 Month Day Year

Race/Ethnic data collection:

Are you Hispanic/Latino?

☐ Yes ☐ No

What is your race? (check all that apply)

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

Category:

☐ Infant	☐ Expecting/estimated delivery date_____
☐ Child	☐ Breastfeeding/del date_____
☐ Senior	☐ Post Partum (non BF)/del date_____

Categorical Verification _____

Household Income $ _____ _____
☐ Weekly ☐ Monthly ☐ Yearly # supported by this income

Income source (circle all that apply):

SS	SSI	SS Disability	VA	Unemployment
Pension	ADC	Child Support	Interest	Wages
Other:				

Determined:
☐ Eligible
☐ Not Eligible
☐ Waiting list

Income Verification_____

Address Verification_____

Even Number Recert Date of Contact _____ Staff Initials ____
☐ Term (not interested) ☐ Continue for 6 months

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 NE Department of Health and Human Services.

_____
Signature Title

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

If Yes, where? _____

Date last received food? _____

Have you been on the WIC program?
☐ Yes ☐ No
If Yes, where? _____

Date last received vouchers? _____

First visit to apply for program (this application)
_____

Date certified/denied_____

Date food first issued (this certification)
_____

Date eligibility data taken
_____

RECERTIFICATION

First visit to apply for program (this application)
_____

Date certified/denied_____

Date food first issued (this certification)
_____

Date eligibility data taken
_____

Name, address, phone # or category changes:

If category change:
Cat. verification_____

Household Income $ _____ _____
☐ Weekly ☐ Monthly ☐ Yearly # supported by this income

Income source (circle all that apply):

SS	SSI	SS Disability	VA	Unemployment
Pension	ADC	Child Support	Interest	Wages
Other:				

Determined:
☐ Eligible
☐ Not Eligible
☐ Waiting list

Income Verification_____

Address Verification_____

Even Number Recert Date of Contact _____ Staff Initials ____
☐ Term (not interested) ☐ Continue for 6 months

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 NE Department of Health and Human Services.

_____
Signature Title