South Carolina Department of Social Services

COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

County No.: ______________________ Food Bank: ❑ GH ❑ LC ❑ HU ❑ HH Site No.: ______________________

Applicant Information (Please Print Clearly)

Applicant Name:	SSN:	Date of Birth:	Sex:	Application Date:
Street Address:	City:	State:	Zip Code:	Telephone: ( )
Authorized Representative Name:		Authorized Representative Telephone:		

Racial/Ethnic Data
(Data will not affect consideration of application for assistance. This information is requested solely to ensure compliance with Federal Civil Rights laws.)

Ethnic Category
Are you Hispanic or Latino? (Select only one)
❑ Yes ❑ No

Racial Category (Select one or more)
❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ American Indian or Alaska Native and White
❑ Asian and White
❑ Black or African American and White
❑ American Indian or Alaska Native and Black or African American
❑ Multiple Races Not Shown Above

This application is being made 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 responsibilities 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.

I certify that I have not applied for or received benefits from any other Commodity Supplemental Food Program (CSFP) site in the month of application; nor will I apply for and receive CSFP benefits in subsequent months at the same time as I receive benefits under this application, if I am certified. ❑ Yes ❑ No

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: 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) 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.

Signature of Applicant: ______________________________ **Date:** ______________________

Certification Information (To be completed by CSFP Site Staff Only.)

❑ Initial Certification ❑ Recertification	**Action Date:**
Gross Household Income: $ ____________ ❑ Monthly ❑ Yearly	Total Number of Household Members:
Status: ❑ Eligible (Active) ❑ Eligible (Waiting list) ❑ Denied	**Reason for Denial:**

Eligibility Verification (Document the verification used for each eligibility criteria listed below)

Eligibility Criteria	Verification Source
Age	Verification Type/Date on Documentation:
Income Eligibility	
Categorical Income Eligibility	
Residence	Verification Type/Date on Documentation:

Nutrition Education: Nutrition Education discussed and/or materials provided? ❑ Yes ❑ No

I hereby certify that this assessment was made on the basis of information contained within agency files. All eligibility criteria were applied as defined by the South Carolina Department of Social Services.

Agency Certification Staff Printed Name: ______________________________

Agency Certification Staff Signature: ______________________________ Title: ______________________

INSTRUCTIONS FOR DSS FORM 16168

Complete application in black or blue ink only. Completed applications must be submitted to the local agency by the 1st of the month.

To Be Completed by Certification Staff Only

County Name	*Applicant's* county of residence.
Food Bank Name	Check the local food bank.
LDA	Enter the the CSFP site number.

To Be Completed by the Applicant

Applicant Name	Name of person for whom programs are being requested.
Social Security Number	Enter the applicant's SSN or use the last 3 site number and birthdate.
Date of Birth	Applicant's birth date.
Sex	Applicant's sex.
Application Date	Date completed application is received by the certification site.
Street Address	Applicant's street address number and name.
City	Applicant's city of residence.
State	Applicant's state of residence.
Zip Code	Applicant's zip code.
Telephone Number	Applicant's telephone number.
Authorized Representative Name	Enter the name of the authorized representative (proxy) designated by the applicant.
Authorized Representative Telephone	Enter the telephone number of the authorized representative (proxy).
Ethnic & Racial Data	Check as appropriate for applicant.
Civil Rights check box	Check appropriate box.
Signature of Applicant	Signature of person for who benefits are being requested. If the application is being made by an Authorized Representative, the application must be signed by the applicant to be a valid application and an Authorized Representative (Proxy) Designation Form has to be completed for the Proxy and signed by the applicant.
Date	Date application signed by applicant.

To Be Completed by Certification Staff Only

Action Date	Date eligibility/certification is determined.
Eligibility Notification Given/Sent	Check as appropriate.
Gross Household Income	Document the gross household income that will be used to determine the eligibility of the applicant: (Note: Only consider the gross income of those individuals sharing household living expenses with the applicant).
Date Eligibility Notification Letter Given/Sent	Document the date the notice was given/sent to the applicant.
Other Household Members	List the names of other household members. Enter the Date of Birth and check the box next to DOB for CSFP household members.
Total Number of CSFP Household Members	Enter the total number of household members applying for CSFP.
Status	Indicate the disposition on the request for program benefits.
Reason for Denial	Document (if necessary) why the application was denied.
Verification Source	Completely document the type, document date, expiration date if any), any document numbers/identifiers and/or gross income amounts of the verification used to determine program eligibility. Also document periods of eligibility as indicated on the document.
Nutrition Education	Indicate if nutrition education was discussed and/or nutrition education information was given to the applicant.
Agency Certification Staff Printed Name/Signature	Printed Name and signature of agency certification staff processing the application.