Commodity Supplemental Food Program Application
Winnebago Tribe of Nebraska
Food Distribution Programs
Revised (04/2022)

Name		Address	
City	State	County	Telephone Number
Home delivery: ☐ Pick up: ☐		Directions for home delivery, if needed:	

1. Are you Hispanic or Latino? ☐ Yes ☐ No

2. What is your race? (Select one or more):

☐ American Indian or Alaska Native; ☐ Asian; ☐ Black or African American;

☐ Native Hawaiian or Other Pacific Islander; ☐ White

Household Members (List ALL household members)	Date of Birth	Form of ID Presented by the applicant*

*** DL=Drivers License, BC=Birth Certificate, OT=Other (Specify), NA=Not Available (Signed Affidavit Attesting Age)**

This must be read to or read by the applicant:

This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that it is illegal to participate in the CSFP at more than one local agency and to make false or misleading statements, misrepresent, conceal or withhold facts regarding my household income. I am also aware that as a result, I could be disqualified from the program for a period not to exceed 12 months. 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 [ ]

Applicant Signature	Date
Caseworker/Program Director Signature	Date

Applicant's Right and Responsibilities

- 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;
- The local agency will make nutrition education available to participants and will encourage them to participate;
- The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate;
- **Participants must report changes in household income or composition within 10 days after the change becomes known to the household.**

Income Verification:

Elderly persons (aged 60 years or older) are income-eligible for CSFP if their gross income is at or below 130% of federal poverty thresholds. Income means gross income before deductions for such items as income taxes, employees' social security taxes, insurance premiums, and bonds.

Document all household income below. If available, provide income documentation to the case worker along with the application. Proof of income is not required.

All Household Members	Wages	Social Security/ Retirement/ Pension	Public Assistance	Self Employment/ Unemployment	Other	Subtotals
Total Household Income:						**$**

For Office Use Only:

Maximum income for a household of ____ is $ _____ Certification period: _____ to _____

If more than one person in the household, list member(s) eligible and number of food packs desired:

_____

If more than one person in the household, list member(s) NOT eligible to receive Commodity Supplemental foods:

_____

"This institution is an equal opportunity provider."