

**Minnesota Department of Job and Family Services (MDJFS)
Commodity Supplemental Food Program (CSFP) Certification Form**

Local Agency _____ Distribution Site _____

APPLICANT INFORMATION

PLEASE PRINT

Applicant Name _____
Last First Middle Initial

Address _____
Street or Box Number City & State County Zip Code

Telephone () _____ Household Size _____ Income _____
Date of Birth _____ Sex – Male Female Handicap - Yes No
Race/Ethnic Code- _____ Black, not of Hispanic Origin _____ Asian or Pacific Island
_____ American Indian or Alaskan Native _____ White, not of Hispanic Origin

Proxy – Name _____ Phone () _____
Name _____ Phone () _____

Please read the following statement carefully, then sign the form and write in today's date. 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 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 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 for the program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.) YES () NO ()

Signature _____ Date _____

Are you currently receiving Food Stamp Assistance? If Yes, How Much? YES () NO () _____
If no, do you want information about Food Stamp Assistance in addition to CSFP? YES () NO ()

TO BE COMPLETED BY PROGRAM STAFF

Date of Application (this certification) _____

Date Certified/Denied _____

Category: Child _____ Elderly _____

Eligibility

Verification – Categorical _____ Residency _____

Determination – Eligible _____ Not Eligible _____ Waiting List _____

I hereby certify that this assessment was made in compliance with federal and state program guidelines. All eligibility criteria were applied as defined by the MDJFS.

Signature _____ Title _____ Date _____

RECERTIFICATION

Date of Recertification _____

Eligibility

Verification _____ Categorical _____ Residency _____

Determination _____ Continue /6 months _____ Terminate _____ Waiting List _____

Changes _____

Signature _____ Title _____ Date _____

APPLICANT AGREEMENT

I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.

Program benefits are provided in connection with the receipt of Federal Assistance.

Program Officials may verify information on this form.

I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.

I may appeal any decision by the local agency regarding eligibility for CSFP. A request for a fair hearing can be submitted to the local agency.

The local agency will make health service and nutrition education materials available to me and I am encouraged to participate in these services.

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 is not allowed and will result in being removed from at least one program.

I have been advised on my rights and obligations under the CSFP program.

If participating in CSFP, I will pick up food as directed. Failure to pick up food as directed may result in being dropped from the program.

I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.

I understand CSFP is a supplemental rather than a food program.

I consent to the release of information by program staff to WIC agency, another CSFP agency to which I may transfer, and to officials of USDA, Minnesota Department of Health and the Minnesota Department of Job and Family services.

REQUESTING A FAIR HEARING

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

1. I may talk with the CSFP workers at this distribution site, contact the local CSFP program director, or the CSFP State Program Director at the Minnesota Department of Job & Family Services to have my case reviewed.
2. If I am not satisfied with 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 notice of denial or termination of benefits.
3. I will be contacted by the State Program Director or his/her designated Representative within a week after my request is received. At this time a date will be set for a 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 CSFP office at the Minnesota Department of Job & Family Services.
5. If my representative or I do not appear for the hearing or if I request the Hearing to be canceled, it will be canceled.
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 CSFP must follow the decision. I must follow the decision also.
8. If I do not agree with the decision made at the local hearing, I may ask for an appeal by contacting the state agency as follows: CSFP – Office of Family Stability, Minnesota Department of Job & Family Services at 85 East 7th Place Suite 400, St. Paul, Minnesota, 55164-0882. If I desire and 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 agency CSFP Director. A copy is available upon request.

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the bases of race, color, national origin, sex, age or disability. To file a complaint of discrimination write, USDA, Director, Office of Civil Rights, Room 26-W, Whitten Building, 1400 Independence Avenue SW, Washington, D.C., 20250-9412 or call 202-720-5964 (Voice and TDD) USDA is an Equal opportunity provider and employer.

USDA Nondiscrimination Statement

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, religious creed, disability, age, political beliefs, 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.