South Carolina Department of Agriculture

COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

Contracted Food Bank: **HARVEST HOPE FOOD BANK**

Distributing Agency *(if different from Contracting Food Bank)*:_____ **Site #:**_____

County Name:_____ Application Date: _____

Applicant Information (Please Print Clearly)				
Applicant Name:	Date of Birth:	Age:	Sex:	Social Security Number:
Residential Address:	City:	State:	Zip Code:	Home Phone:
Mailing Address:	City:	State:	Zip Code:	Cell Phone:

Racial/Ethnic Data (Optional)

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

Ethnic Category (Select only one)	**Racial Category** (Select only one)
Are you Hispanic or Latino? ☐ Yes ☐ No	• American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White • Other

Household Income

Did you provide a copy of the current adjusted household income guidelines at 130 percent Federal Poverty Income Guideline to applicant? ☐ Yes ☐ No

Gross Household Income: $_____ Source(s) of Income: _____

❑ Monthly ❑ Twice-monthly ❑ Every 2 Weeks ❑ Weekly

Total Household Members_____**(**Check box if included for CSFP) **Total CSFP Household Members**_____

List the name of all household members below and place a check in the box by the name of all CSFP participants.

	•		•
	•		•
	•		•

I hereby certify that: I understand that the foods given to me are to be used by person listed hereon and as directed by the distributing agency. I authorize the following person(s) to pick up food for me from the Food Distribution Center.

1. **Name:** **Phone:**

2. **Name:** **Phone:**

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

Eligibility Criteria Verification Source: **Age Verified:**

Date on Documentation:

"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 to other organizations for use in determining my eligibility for participation in other public assistance programs and for outreach purposes." (Please indicate decision by placing a checkmark in the appropriate box.) ☐ Yes ☐ No

Signature of Applicant:_____ **Date:**_____

Witness Signature (if signature above is an "X") _____

CSFP Eligibility Determination and Participant Agreement

Certification Approval **(To be signed by CSFP Contracted Distributing Agency Staff Only)**	
Status: · Eligible (Active) · Eligible (Waiting List) · Denied/Discontinued	**Eligibility Notification: · Letter · Verbal** **Date:**
Certification Period Twelve months _____ **to** _____ **Distribution Information** _____	
Reason for Denial/Discontinuation:	**Denial/Discontinuation Letter Given/Sent: · Yes · No** **Date:**

I hereby certify that all eligibility criteria were applied as defined by the South Carolina Department of Agriculture.
Printed Name:_____**Title:** _____

Agency Certification Staff Signature: _____

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.

Participant Agreement

Changes to household income must be reported within 10 days of changes becoming known.
Any appeals to decisions regarding eligibility must be made within 60 days.
The local agency will make health services and nutrition education available and you are encouraged to participate.
Missing two consecutive months distributions will result in removal from the program.
The CSFP program is intended as a supplemental food program only. It does not provide 100% of nutritional needs.
Participants must be recertified every 12 months.

Participant Signature: _____

Date: _____

Revised 6/28/19