Site _____

2023-2024 MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

RETURN THIS APPLICATION TO:
The Aroostook Agency on Aging
P.O. BOX 1288 Presque Isle, Maine 04769

Please complete a separate application for each person enrolling in the program.

Name _____ **Date of Birth** _____

Address _____**City** _____ **ZIP** _____

County _____ **Phone** _____ **Is mailbox full or not set up?**_____

Type of Identification Provided (complete this line in person)_____

Ethnicity: Is the applicant Hispanic or Latino? (Response will not influence eligibility) ☐ **Yes** ☐ **No**

Race: Please indicate applicant's race(s) using ONE OR MORE: (For civil service statistical purposes only)

1) American Indian or Alaskan Native ☐ **Yes** ☐ **No**

2) Asian ☐ **Yes** ☐ **No**

3) Black or African American ☐ **Yes** ☐ **No**

4) Native Hawaiian or Other Pacific Islander ☐ **Yes** ☐ **No**

5) White ☐ **Yes** ☐ **No**

Age: Is the applicant 60 years old or older? ☐ **Yes** ☐ **No**

INCOME: What is the applicant's household size (number of persons in economic / family unit)? _____

What is the applicant's household income (USD)? $_____

Updated January 17, 2023. This table indicates 130% of the federal poverty line.

Household Size	Annual	Monthly	Weekly
1…….	$18,954	$1,580	$364.50
2…….	$25,636	$2,136	$493
3…….	$32,318	$2,693	$621.50
4…….	$39,000	$3,250	$750
5…….	$45,682	$3,807	$878.50
6…….	$52,364	$4,364	$1,007
7…….	$59,046	$4,921	$1,135.50
8…….	$65,728	$5,477	$1,264
For each add'l household member, add…	$6,682	$556	$128.50

Is the applicant's household income **LESS** than the amount listed in the above table? ☐ **Yes** ☐ **No**

YOUR RIGHTS AND RESPONSIBILITIES IN THE MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

I AGREE TO:

- Provide proof of my income, address, and identification ***if requested***.
- Give staff correct information about my current household and its income.
- Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

I UNDERSTAND THAT:

- CSFP will provide supplemental foods.
- The CSFP local agency will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
- The CSFP local agency will provide nutrition education to all program participants and will encourage participation.
- I will be dropped from this program if I participate in another CSFP.
- I have the right to appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.
- If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
- I may be taken off the program if I sell or barter with CSFP foods.
- I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits. It may also lead to disqualification from CSFP.

CERTIFICATION: The following statement must be read by, or to, the applicant or caretaker before signing.

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 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 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 ☐

Signature: _____ **Date:** _____

Any questions please contact the agency that provided this application.

STAFF USE ONLY:	**Certifying Action Taken**
Approved _____	**For period ending last day**_____
ID Verified in person_____	**Date Put on Waiting list if necessary**_____
Denied _____	**Letter of Fair Hearing Given**_____
Date_____	**Signature of Verifying & Determining Official** _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.