Ohio Department of Job and Family Services

COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) CERTIFICATION

Return completed application to
cheri@seagatefoodbank.org
Street Address or Box Number
526 High Street
City, State Zip Code
Toledo, Ohio 43609

Local Agency
Toledo SeaGate Food Bank
Distribution Site

APPLICANT INFORMATION *PLEASE PRINT*

Date	Applicant Last Name	First Name	Middle Initial	Date of Birth	Sex ☐ Male ☐ Female

Home Address *(Street Address or Box Number)*	City, State	County	Zip Code
Mailing Address *(Street Address or Box Number)*	City, State	County	Zip Code

Primary Telephone *(include area code)*	Number of People in Household

Income $	How often is the income received? ☐ Weekly ☐ Yearly ☐ Monthly

Alternate Telephone *(include area code)*	Ethnicity - Are you Hispanic or Latino? ☐ Yes ☐ No	Race ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White	Handicap ☐ Yes ☐ No

Authorized Representative Information	I authorize the following individual to act on my behalf in matters related to CSFP.	
Authorized Representative	Name	Phone *(include area code)*
	Address (*Street Address or Box Number)*	Zip Code

Proxy Information	In the event that I am unable to pick up my commodity food box from the distribution site, I authorize the following individual to pick up my commodity food box and sign the receipt log for me. I understand that I accept full responsibility for the actions of my proxy and will inform him/her of the proper procedure for commodity pick up.	
Proxy	Proxy #1 Name	Phone *(include area code)*
	Proxy #2 Name	Phone *(include area code)*

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 file a Program Discrimination Complaint as a USDA Customer | Office of the Assistant Secretary for Civil Rights 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.

APPLICANT AGREEMENT

1. I certify that the information I have provided for eligibility determination is correct to the best of my knowledge.
2. This application is being completed in connection with the receipt of Federal assistance.
3. Program officials may verify information on this form.
4. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution under State and Federal law.
5. I may appeal any decision by the local agency regarding my eligibility for the CSFP. A request for a fair hearing can be submitted to the local agency.
6. The local agency will make health service and nutrition education materials available to me and I am encouraged to participate in these services.
7. I understand that participating in more than one CSFP program at the same time is not allowed and will result in being removed from the program.
8. **I understand that I may be dropped from the program if I fail to pick up my commodity food box two (2) months in a row with no communication.**
9. I understand that the foods provided by CSFP are intended for the participant for whom they are prescribed.
10. I understand CSFP is a supplemental rather than a total food program.
11. I consent to the release of information by program staff to another CSFP agency to which I may transfer, and to officials of USDA and the Ohio Department of Job & Family Services.
12. I understand that I must report changes in household income, or changes in the composition of the household, within ten days after the change becomes known to the household.
13. I understand that physical abuse, or the threat of physical abuse, of CSFP staff is a program violation. My participation in CSFP may be terminated for this and for other program violations.
14. I have been advised on my rights and responsibilities under the CSFP.

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 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.

Your response to the following question does not affect consideration of this application. 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

TO BE COMPLETED BY PROGRAM STAFF

Date of Initial Application Received	Eligibility			Determination	Date Certified/Denied
	Income	☐ YES	☐ NO	☐ Eligible	
	Residency	☐ YES	☐ NO	☐ Not Eligible	Certification Period:
	Age	☐ YES	☐ NO	☐ Eligible and On Waiting List	From to

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 ODJFS.

Signature	Title	Date

Date Recertification Due By:	In order to continue receiving CSFP benefits, you will need to complete the recertification process.

Notes:

Tear off this section and give it to the applicant

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REQUESTING A FAIR HEARING

If I am dissatisfied with any decisions made regarding the 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 Ohio Department of Job & Family Services to have my case reviewed.
2. If I am not satisfied with the 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 the 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 Ohio Department of Job & Family Services.
5. If I do not appear for the hearing or if my authorized representative or 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 local agency 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 Assistance, Ohio Department of Job & Family Services, 4020 East 5th Ave. PO Box 183204, Columbus, OH 43218-3204. If I desire an 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.

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