Indiana Department of Health | Division of Women, Infants & Children

Commodity Supplemental Food Program (CSFP)
Participant Application

Form CSFP 0003
Effective 04/01/2025

Local Agency	**Distribution Site**

Household Information (PLEASE PRINT) *To be completed by Applicant, Household Member, Authorized Representative or Agency that is determining eligibility.*

Name of Applicant (Last, First, Middle Initial)		Date of Birth
Address (Street, City, State, ZIP Code)	**Area Code and Telephone No.**	**Gender** ☐ M ☐ F ☐ NB

Have you ever received food from the Commodity Supplemental Food Program? ☐ Yes ☐ No

If yes, where? _____

Date applicant last received food from the CSFP: _____

Income Description	**Amount**	**Frequency**

Total number of household members	Total gross income (before deductions) of all household members **$** ☐ Weekly ☐ Monthly ☐ Yearly	**Note:** SNAP benefits do not count as income.

CSFP Income Guidelines (150% of poverty)

I hereby certify that my household income is at or below the following guidelines: ***Yes [ ]*** ***No [ ]***

Household Size	**Annual**	**Monthly**	**Household Size**	**Annual**	**Monthly**
1	$ 23,475	$ 1,957	5	$ 56,475	$ 4,707
2	$ 31,725	$ 2,644	6	$ 64,725	$ 5,394
3	$ 39,975	$ 3,332	7	$ 72,975	$ 6,082
4	$ 48,225	$ 4,019	8	$ 81,225	$ 6,769
	For each additional household member, add			$ 8,250	$ 688

To be completed by program staff

Eligibility	**Category**	**Determination**	Date Determination Notice Sent:
Income ☐ Yes ☐ No	☐ Age eligible	□ Eligible	Determination Date:
	☐ Not categorically eligible	□ Not Eligible	Date of Initial Visit:
Residence ☐ Yes ☐ No		□ Eligible–On Waiting List	Certification Period _____ - _____

Signature-Individual Making Determination	Title-Individual Making Determination

Participant Acknowledgement

If placed on the program, 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 if I choose to send an alternate (proxy) to pick up my food, I must have a completed Proxy Form on file designating that person.

I understand that the food provided by this program is intended for the participant for whom it is prescribed.

Fair Hearing

I may appeal any adverse decision made regarding my eligibility for the Program. I or my caregiver may request a fair hearing by making a verbal or written request to a State or Local Agency official within sixty (60) days of the notification date of an adverse action.

MUST BE COMPLETED: If applicant refuses, fill in this section based on intake person's visual determination.

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Race: ***check all that apply***

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

Native Hawaiian or Other Pacific Islander ☐ White ☐

Certification (MUST BE READ TO APPLICANT BEFORE SIGNING):

This application is 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, including the right to appeal any decision made by the local agency regarding my denial or termination from the Program and that the local agency will make nutrition education available to me and I am encouraged to participate. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge. I authorized 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 – Applicant	Date	Name of Proxy – Optional *(print)*

STAFF CERTIFICATION: I certify I have read this page to the applicant and all items are completed.

Staff Printed Name	Date	Staff Signature

NONDISCRIMINATION:

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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;

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

For additional assistance information, please see next page.

For information about Supplemental Security Income (SSI)

Visit https://www.ssa.gov/ or find your local Division of Family Resources office at https://www.in.gov/fssa/dfr/ebt-hoosier-works-card/find-mylocal-dfr-office/

For information about Medicaid or SNAP

Visit https://fssabenefits.in.gov/bp/#/ to apply online
OR
Find your local Division of Family Resources office at
https://www.in.gov/fssa/dfr/ebt-hoosier-works-card/find-my-local-dfr-office/
OR
Get a copy of the map and local listings from the local agency.

Apply for Medicare Part D Extra Help program

The Extra Help program helps people with limited income and resources lower or cut Part D costs.

Medicare Part D provides drug coverage. The Extra Help program helps with the cost of your prescription drugs, like deductibles and copays. You can apply for Extra Help any time before or after you enroll in Part D.

Documents to help you prepare

Gather these documents for you and your spouse:

- Bank statements and tax returns
- Individual Retirement Account (IRA) or 401(k) account balances
- Statements for pensions, Veterans' benefits, annuities, and Railroad Retirement Board benefits

Apply for Extra Help online at https://secure.ssa.gov/i1020/Ee001View.action

For support completing this task

Set up an appointment

Available in most U.S. time zones Monday through Friday, 8 a.m. to 7 p.m., in English, Spanish, and other languages.
Call +1 800-772-1213
Tell the representative you want to set up an appointment to apply for Part D Extra Help.
Call TTY +1 800-325-0778 if you're deaf or hard of hearing.

Learn more about Extra Help

Visit Medicare.gov for more information about the Extra Help program.

Medicare/Medicaid Coordination

https://www.cms.gov/medicare/medicaid-coordination/qualified-medicare-beneficiary-program

For information about Senior Farmers Market Nutrition Program (SFMNP)

https://www.medialab.com/dv/dl.aspx?d=2656455&dh=4300e&u=95194&uh=670d6