

**South Carolina Department of Social Services
COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION**

County No.: _____ Food Bank: GH LC HU HH Site No.: _____

Applicant Information (Please Print Clearly)				
Applicant Name:	SSN:	Date of Birth:	Sex:	Application Date:
Street Address:	City:	State:	Zip Code:	Telephone: ()
Authorized Representative Name:		Authorized Representative Telephone:		

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

Ethnic Category	Racial Category (Select one or more)	
Are you Hispanic or Latino? (Select only one) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> American Indian or Alaska Native and White
	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian and White
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American and White
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> American Indian or Alaska Native and Black or African American
	<input type="checkbox"/> White	<input type="checkbox"/> Multiple Races Not Shown Above

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 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.

I certify that I have not applied for or received benefits from any other Commodity Supplemental Food Program (CSFP) site in the month of application; nor will I apply for and receive CSFP benefits in subsequent months at the same time as I receive benefits under this application. Yes No

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.

Signature of Applicant: _____ Date: _____

Certification Information (To be completed by CSFP Site Staff Only.)

<input type="checkbox"/> Initial Certification <input type="checkbox"/> Recertification	Action Date:
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Gross Household Income: \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Total Number of Household Members:
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Status: <input type="checkbox"/> Eligible (Active) <input type="checkbox"/> Eligible (Waiting list) <input type="checkbox"/> Denied	Reason for Denial:
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Eligibility Verification (Document the verification used for each eligibility criteria listed below)

Eligibility Criteria	Verification Source
Age	Verification Type/Date on Documentation:
Income Eligibility	
Categorical Income Eligibility	
Residence	Verification Type/Date on Documentation:

Nutrition Education: Nutrition Education discussed and/or materials provided? Yes No

I hereby certify that this assessment was made on the basis of information contained within agency files. All eligibility criteria were applied as defined by the South Carolina Department of Social Services.

Agency Certification Staff Printed Name: _____

Agency Certification Staff Signature: _____ Title: _____

INSTRUCTIONS FOR DSS FORM 16168

Complete application in black or blue ink only. Completed applications must be submitted to the local agency by the 1st of the month.

To Be Completed by Certification Staff Only

County Name *Applicant's* county of residence.
Food Bank Name Check the local food bank.
LDA Enter the the CSFP site number.

To Be Completed by the Applicant

Applicant Name Name of person for whom programs are being requested.
Social Security Number Enter the applicant's SSN or use the last 3 site number and birthdate.
Date of Birth Applicant's birth date.
Sex Applicant's sex.
Application Date Date completed application is received by the certification site.
Street Address Applicant's street address number and name.
City Applicant's city of residence.
State Applicant's state of residence.
Zip Code Applicant's zip code.
Telephone Number Applicant's telephone number.
Authorized Representative Name Enter the name of the authorized representative (proxy) designated by the applicant.
Authorized Representative Telephone Enter the telephone number of the authorized representative (proxy).
Ethnic & Racial Data Check as appropriate for applicant.
Civil Rights check box Check appropriate box.
Signature of Applicant Signature of person for who benefits are being requested. If the application is being made by an Authorized Representative, the application must be signed by the applicant to be a valid application and an Authorized Representative (Proxy) Designation Form has to be completed for the Proxy and signed by the applicant.
Date Date application signed by applicant.

To Be Completed by Certification Staff Only

Action Date Date eligibility/certification is determined.
Eligibility Notification Given/Sent Check as appropriate.
Gross Household Income Document the gross household income that will be used to determine the eligibility of the applicant: (Note: Only consider the gross income of those individuals sharing household living expenses with the applicant).
Date Eligibility Notification Letter Given/Sent Document the date the notice was given/sent to the applicant.
Other Household Members List the names of other household members. Enter the Date of Birth and check the box next to DOB for CSFP household members.
Total Number of CSFP Household Members Enter the total number of household members applying for CSFP.
Status Indicate the disposition on the request for program benefits.
Reason for Denial Document (if necessary) why the application was denied.
Verification Source Completely document the type, document date, expiration date if any), any document numbers/identifiers and/or gross income amounts of the verification used to determine program eligibility. Also document periods of eligibility as indicated on the document.
Nutrition Education Indicate if nutrition education was discussed and/or nutrition education information was given to the applicant.
Agency Certification Staff Printed Name/Signature Printed Name and signature of agency certification staff processing the application.