State of Hawaii
Commodity Supplemental Food Program (CSFP)
Participant Application

Staff use only

Application Date: _____ _____ Staff Initials

Recertification Dates: (every 12 months)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

1. Last Name: _____
2. First Name: _____
3. Address: _____

_____

4. Gender: ☐ Male ☐ Female 5. Date of Birth: _____ 6. Telephone number: _____

Racial and/or ethnic data collected on this form has no effect on the eligibility determination of the household. Please select at least one of the following:

7. Are you Hispanic or Latino? ☐ Yes ☐ No

8. (You may select more than one)
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian

Please see attached for Household Income Limits

9. Monthly Household Income: $ _____ 10. Total number of people in the household: _____

11. Source of Income: ☐ No Income ☐ Disability ☐ Pension ☐ Social Security ☐ SSI ☐Wages ☐Unemployment

12. Have you previously been enrolled in the Commodity Supplemental Food Program? ☐Yes ☐ No

13. **PROXY**

Only complete this information if you authorize someone else to pick up your CSFP box

I hereby authorize the following individuals to act as my authorized representative for CSFP

Name: _____ Telephone Number: _____
Name: _____ Telephone Number: _____

STAFF USE ONLY

Client ID: _____

Site Name: _____ Site #: _____

Wait List Date: _____ Wait List Notification Date: _____

Revised 11/2019

PLEASE CHECK BOXES FOR ACKNOWLEDGMENT

☐ 14. **Enrollment** I will be enrolled for 12 months at a time and be required to recertify every year. I must continue to meet all eligibility requirements at the time of recertification.

☐ 15. **I agree** to inform the Hawaii Foodbank in writing with 10 days of any changes in my contact information.

☐ 16. **Pick up** I may actively only participate at **ONE DISTRIBUTION SITE.** I may request a site change with a written request. If I do not pick up a box for three (3) months in a row, I will be removed from the program for being an inactive participant.

☐ 17. **Reapply** If I am removed from the program for being an inactive participant, I am allowed to reapply for benefits by filling out another CSFP application. If a wait list occurs, however, I understand my application will go on the list according to the date it was received.

☐ 18. **I cannot** trade/sell CSFP food or purchase/use someone else's CSFP food for my household.

☐ 19. **Termination** I will be notified in writing of termination and have the right to a fair hearing.

☐ 20. **Fair Hearing** If I am found ineligible for this program during a recertification review, I have the right to a fair hearing in accordance with the provisions of Federal and State law.

☐ 21. 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, religious creed, disability, age, political beliefs, 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.

22. 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 both CSFP and WIC benefits simultaneously. 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. ☐ **YES** ☐ **NO**

23.	24.	25.
Print Name of Participant	Signature of Participant	Date

State of Hawaii

Commodity Supplemental Food Program

2020 HOUSEHOLD INCOME GUIDELINES

Household Size	Monthly	Annually
1	$ 1,591	$ 19,084
2	$ 2,149	$ 25,779
3	$ 2,707	$ 32,474
4	$ 3,265	$ 39,169
5	$ 3,822	$ 45,864
6	$ 4,380	$ 52,559
7	$4,938	$59,254
8	$5,496	$65,949

For each additional household member, add $558