



Staff use only:
 Received, date: _____
 Approved Denied
 Wait List, date: _____

COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

CSFP is a senior food assistance program. Community members who are age 60+, live in Cumberland, Oxford or York County & meet income requirements are eligible. This program is per person not per household, but every individual must complete and submit an application.

Name: _____ Date of Birth: ____/____/19____

Address: _____ Town: _____ ZIP: _____

Phone: _____ CSFP Site (Where did you sign up?): _____

Is there a friend, neighbor, aid or case worker who will be helping with this or picking up for you?

Proxy Name: _____ Proxy Phone: _____

How do you identify? Please check all that apply.

- American Indian or Alaska Native Spanish/Hispanic/Latino (any race)
 Asian White
 Black or African American Other:
 Native Hawaiian or Pacific Islander If other, please specify _____

Please verify your income based on your household size. Check the range that applies.

Household Size	Monthly Household Income	Household Size	Monthly Household Income
1	___\$0 - \$1,354	4	___\$0 - \$2,790
2	___\$0 - \$1,832	5	___\$0 - \$3,269
3	___\$0 - \$2,311	6	___\$0 - \$3,748
>6	___\$0 - (For each additional household member add \$479.00)		

By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete to the best of my knowledge and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I understand that I must notify CSFP of all changes of income, address or household composition within 10 days.

I understand that CSFP will provide supplemental foods however I may be taken off the program if I do not pick up food 3 months in a row without contacting staff, if I sell CSFP foods or if I intentionally withhold information pertaining to my eligibility. I am aware that program officials may need to verify information on this form and that I am obligated to cooperate.

I certify that I will not receive CSFP benefits at more than one site. Furthermore, I am aware that the information provided may be released to other organizations administering assistance programs for use in determining my eligibility and to detect and prevent dual participation.

Signature: _____ Date: _____

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Please return this form to:

Wayside Food Programs, c/o CSFP, P.O. Box 1278, Portland, ME 04104

