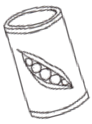 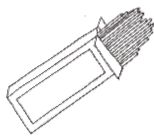

Staff use only:
☐ Received, date: ___________
☐ Approved ☐ Denied
☐ Wait List, date: ___________

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
____Asian
____Black or African American
____Native Hawaiian or Pacific Islander
____Spanish/Hispanic/Latino (any race)
____White
____Other:
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