



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 COMMUNITY FOOD AND NUTRITION ASSISTANCE
 COMMODITY SUPPLEMENTAL FOOD PROGRAM
PARTICIPANT APPLICATION

Appendix 2.1A

Is the applicant or any qualifying household member participating in WIC or CSFP at another site? YES NO
 Improper use or receipt of CSFP benefits as a result of dual participation or other **program violations may lead to a claim against the individual** to recover the value of the benefits, and may lead to disqualification from CSFP.

NAME OF APPLICANT _____ **NAME OF GUARDIAN (if applicable)** _____

ADDRESS _____ **CITY/STATE/ZIP CODE** _____ **TELEPHONE NUMBER** _____

Social Security No (SSN) or Client Case # (DCN)* _____ **APPLICANT'S DATE OF BIRTH** _____ **TOTAL NUMBER LIVING IN HOUSEHOLD** _____

NAMES OF QUALIFYING HOUSEHOLD MEMBERS (continue on back)	AGE	DATE OF BIRTH	SSN or DCN

* **Women, infants and children – enter applicant DCN and show proof of receiving food stamps or family member receiving TANF or Medical Assistance OR enter applicant SSN and complete income section below.**

CHANGES MUST BE REPORTED: Participants must report changes in household income or composition within 10 days after the change becomes known to the household.	Indicate the source and amount of current (last month's) income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income would include commissions; strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.		
	HOUSEHOLD INCOME	AMOUNT	HOW OFTEN RECEIVED
	GROSS SALARY, WAGES		
	SOCIAL SECURITY		
	PUBLIC ASSISTANCE (WELFARE)		
	CHILD SUPPORT (ALIMONY)		
	PENSIONS/RETIREMENT		
	SELF-EMPLOYMENT		
	UNEMPLOYMENT		
	OTHER INCOME		
TOTAL HOUSEHOLD INCOME			

RACIAL ETHNIC DATA (OPTIONAL)

Are you of Hispanic or Latino origin? YES NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the Program.
- ✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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, and I may not receive CSFP benefits at more than on 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. 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. (Please indicate decision by placing a checkmark in the appropriate box.) YES NO

SIGNATURE OF APPLICANT OR GUARDIAN _____ DATE _____

UPDATE INFORMATION, SIGN AND DATE FOR CERTIFICATION AFTER WAITING ON LIST _____ DATE _____

***** **FOR CERTIFYING AGENCY USE ONLY** *****

<input type="checkbox"/> IDENTITY/ELIGIBILITY/AGE Describe proof:	<input type="checkbox"/> RESIDENCY VERIFIED <input type="checkbox"/> H&SS HANDOUT GIVEN <input type="checkbox"/> WIC HANDOUT GIVEN	APPLICANT ELIGIBLE? <input type="checkbox"/> Y <input type="checkbox"/> N	CATEGORY: PG PP BF INF CH ELD	CASELOAD AVAILABLE? <input type="checkbox"/> Y <input type="checkbox"/> N	DATE WRITTEN NOTICE GIVEN:
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SIGNATURE AND TITLE OF CERTIFYING OFFICIAL _____	DATE CERTIFIED _____	PERIOD OF CERTIFICATION 1 st Month: _____ Last Month: _____
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