



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

**ELDERLY PARTICIPANT EXTENSION OF CERTIFICATION PERIOD**

NAME OF PARTICIPANT		QUALIFYING HOUSEHOLD MEMBERS (continue on back)	
ADDRESS	CITY/STATE/ZIP CODE	TELEPHONE NUMBER	
<b>FOR CERTIFYING AGENCY USE ONLY</b>			
PARTICIPANT'S ADDRESS AND CONTINUED INTEREST IN RECEIVING CSFP BENEFITS HAS BEEN VERIFIED.			
LOCAL AGENCY HAS SUFFICIENT REASON TO BELIEVE PARTICIPANT/S STILL MEETS THE INCOME ELIGIBILITY STANDARDS (e.g. the elderly person has a fixed income)			
LOCAL AGENCY HAS NOTIFIED PARTICIPANT VERBALLY OR IN WRITING OF THE PERIOD OF THE EXTENSION.			
SIGNATURE AND TITLE OF CERTIFYING OFFICIAL		DATE CERTIFIED	PERIOD OF CERTIFICATION 1 <sup>st</sup> Month:      Last Month:
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