



Certifying Agency: _____ Date: _____

Certifying Agency Address: _____

Applicant's Name: _____

Address: _____

Program standards are applied without discrimination by race, color, national origin, age, sex or disability.

ELIGIBILITY DETERMINATION:

_____ You are eligible to receive CSFP benefits for the period starting the month of _____ and ending the month of _____. Information regarding the time, location, and means of food distribution is attached.

_____ You are eligible to receive CSFP benefits however, we are at maximum caseload and are unable to process your application at this time. You will be placed on a waiting list and contacted when slots become available.

WAITING LIST NOTIFICATION:

_____ We have caseload openings now. Please be informed it is time to re-determine your eligibility for the CSFP. Complete the enclosed forms and bring them and the applicant listed above to our office located at the address above during the hours of _____ - _____ on these days or dates _____.

NOTICE OF CERTIFICATION PERIOD EXTENSION:

_____ Your eligibility for CSFP benefits may be extended through the month of _____ by presenting a document showing your current address to the Certifying Agency listed above prior to the end of the month of _____.

NOTICE OF EXPIRATION OF CERTIFICATION PERIOD:

_____ Your eligibility for CSFP benefits is about to expire effective the last day of the month of _____. Contact the Certifying Agency listed above for additional information.