COLORADO
Office of Economic Security
Division of Food & Energy Assistance

Commodity Supplemental Food Program Application

Name of Applicant			Case No.
Telephone Number	County		
Physical Address (Street, City, Zip Code)			
Mailing Address (If Different) (Street, City, Zip Code)			
Applicant's Date of Birth	Total No. Living In Household		
Names of Qualifying Household Members	Age	Date of Birth	Case Number (For Agency Use Only)

RACIAL ETHNIC DATA (OPTIONAL) Please note: if you choose not to disclose your race and ethnicity, the agency will designate a race and ethnicity based on their observation.

Are you of Hispanic or Latino origin? (For statistical purposes only) ☐ YES ☐ NO

What is your race? (Select one or more) ☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

2021 Income Eligibility Guidelines		
Household Size	Household Income	Household Income
1	$1,396	$16,744
2	$1,888	$22,646
3	$2,379	$28,548
4	$2,871	$34,450
5	$3,363	$40,352
For Each Additional Family Member, Add	$492	$5,902

Indicate the source and amount of last month's income before any deductions, such as taxes and social security. This amount must include income of all household members. "Other" income includes commissions, strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, monthly Income may be calculated as the household's average income during the previous 12 months.

Type of Income	**Monthly Income**	**Monthly Income**
Gross Salary, Wages		
Social Security		
Pensions/Retirement		
Self-Employment		
Unemployment		
Other Income		
Total Household Income		

Program participants must report changes in household income or composition within 10 days after the change becomes known to the household.

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 CSFP benefits at more than one 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

Applicant Signature	Date
Waiting List Certification Signature	Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race,
color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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

I have verified the following for each applicant: Check all that apply. ☐ Identification (List type of ID) ☐ Age ☐ Place of Residence ☐ Household members	Applicant is: ☐ Eligible ☐ Not Eligible Is caseload available? ☐ Yes ☐ No Date notice is provided to the applicant: Certification Period First Month: Last Month:
Certifying Official Signature and Date:	