Welcome to the Senior Grocery Program!

The Senior Grocery Program will provide monthly food boxes of nutritious staple foods. These foods follow a USADA guideline to provide nutrition necessary to a balanced senior diet. You can expect to receive between 35 and 40 pounds of food once a month.

You may qualify for this program if you are a limited income person who is over the age of 60. There are specific income requirements that must be met in order to qualify for this program. They are attached for you to see if you qualify. If you already receive Supplemental Nutrition Assistance Program (formerly known as the food stamp program, Temporary Assistance for Needy Families, or Medicaid, you automatically qualify for the program without additional income verification, although we will need verification that you are receiving SNAP, TANF or Medicaid.

Before you can begin receiving your monthly food box, we must receive a complete application and proof of income or proof of enrollment in one of the above mentioned programs. We will also need a copy of a photo ID and proof of address.

Documents that may be used in order to prove income include: pay stubs, social security statements, bank statements, child support check stubs, or proof of participation in TANF, SNAP or Medicaid.

This is a USDA (United States Department of Agriculture) program that is administered by Marion Polk Food Share Meals on Wheels program. The USDA refers to this program as the Commodity Supplemental Food program, and CSFP bay be an acronym that is used on government forms. Marion Polk Food Share will continue referring to the program simply as the Senior Grocery Program. We are very excited to provide this service.

For further questions please contact Mel Fuller at Marion Polk Foodshare Meals on Wheels: 503-364-2856 or by email at mfuller@marionpolkfoodshare.org.

APPLICATION FOR THE COMMODITY SUPPLEMENTAL FOOD PROGRAM

--CSFP or the Senior Grocery Program —

Please read this page before filling out the form.

HOW DO I APPLY FOR THE COMMODITY PROGRAM?

This application is for the CSFP Program. To determine if you qualify, you must submit this application to Marion-Polk Food Share. You must meet certain program requirements to participate in the program. You are not allowed to be enrolled in the WIC Program and the CSFP Program at the same time. This program allows specified nutritional foods and offers information on nutritional needs.

To apply, you must:

1. Complete this form with all the necessary information
2. Show proof of statements you make on this form, including Proof of income or self-declaration of no-income, Proof of residence, Picture ID

HOW DO I APPLY FOR OTHER PROGRAMS AND SERVICES?

You must contact: Marion-Polk Food Share Meals on Wheels at 2615 Portland Road NE Salem, Oregon or call (503) 36-2856 if you want to apply for other services and programs offered by the agency.

HEARING RIGHTS FOR THE CSFP PROGRAM ONLY:

"Standards for participation in the Program are the same for everyone regardless or race, color, national origin, age, sex, and disabilities; you may appeal any decision made regarding your written denial or termination from the Program. lf your application is approved, nutrition education will be made available to you and you are encouraged to participate. "

If you disagree with denial or termination of assistance, you can request a fair hearing within sixty (60) days of the decision by contacting Marion-Polk Food Share. A request for a fair hearing shall be personally presented, either orally or in writing. A request for an information review must include: 1) Name, address and contact phone number, 2) the reason for the grievance, 3) the action of relief sought.

A hearings officer will arrange a date, time and place convenient to both you and Marion-Polk Food Share. In preparing for the hearing you have the right to examine any documents, including records and regulations that are directly relevant to the hearing. You have the right to be represented by counsel or any other person chosen as your representative. You have the right to a private hearing unless you request a public hearing. You have the right to cross-examine all witnesses. The hearings officer must render a decision within fourteen (14) days of the hearing. If you disagree with the decision of the hearing officer, you may pursue a judicial review.

DATA COLLECTION:

Racial and/or ethnic data collected on this form have no effect on the eligibility determination of the household. Thank you for filling out this form as accurately and completely as possible. The federal government is requesting this information in order to monitor compliance with the federal statutes that prohibit federally assisted programs from discriminating against applicants on this basis. Information obtained will be kept confidential and used for statistical analysis only. Racial and ethnic information is voluntary.

COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

Last Name: ________________________________ First Name: ______________________________________

Mailing Address: ____
City Zip

Street Address (if different from above): ____
City Zip

Phone Number: ______________ Date of Birth: ________________

Complete this section for all other persons in your household:

Last Name	First Name	Relationship	Date of Birth—mm/dd/yy

Total Monthly Income: _____________________________

Source of Household Income:

- ☐ Social Security
- ☐ Social Security Disability
- ☐ SSI
- ☐ Pension
- ☐ Unemployment Insurance
- ☐ Employment
- ☐ Seasonal Employment
- ☐ Foster Children
- ☐ General Assistance
- ☐ TANF
- ☐ Self-Employed
- ☐ Health Insurance
- ☐ Farm Worker
- ☐ Disabled
- ☐ Veteran

Financial Situation Changes:

Do you expect changes in your financial situation or living arrangements in the next few months? ☐ Yes ☐ No

If yes, please explain: ____

____

____

Head of Household's Ethnic Origin:

1) Are you Hispanic or Latino? ____ Yes ______ No

2) What is your race? (Check all that apply)

- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ I decline to answer
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Authorized Representative:

You can authorize someone outside your household to get your food commodities for you.

By signing this form, I hereby authorize (Name): _______________ Phone Number: _________ to provide information to Oregon Housing and Community Services (OHCS) on my behalf regarding the CSFP. I further authorize OHCS and Marion-Polk Food Share to access any records in order to verify information given.

I consent to any legally authorized investigation for confirmation of any information that I provide. I agree to let the State of Oregon Department of Human Services give information to OHCS or Marion-Polk Food Share to determine my eligibility.

I acknowledge that I have received the first page of this application outlining my rights to request a fair hearing if my application is denied. I understand that I must request a hearing within sixty (60) days of the written date of denial.

I further understand that anyone listed in my household CANNOT be enrolled in the WIC and Commodity Supplemental Food Program at the same time. I CANNOT sell or trade commodities or use someone else's commodities for my household.

I also agree to inform the CSFP office if my household income or composition changes. I will provide the new information within ten (10) days of the change.

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 that 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.
☐ Yes ☐ No Please indicate your decision by placing a check mark in the appropriate box.

Applicant Signature: ____ Date: ______________

Witnessed if Signed with an X: _____________________________________ Date: ______________

Staff Member Signature: ____ Date: ______________

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint filing cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer. You may also contact Oregon Housing & Community Services, Food Program Analyst, 725 Summer St NE, Suite B, Salem, OR 97301-1271, (503) 986-2000.

For Office Use Only:

☐ Approved ☐ Denied ☐ Notice of Action—Date: ____________ Staff Initial: __________

Remarks: