MARION POLK FOOD SHARE
MEALS ON WHEELS

Senior Grocery Program

Commodity Supplemental Food Program is a USDA (United States Department of Agriculture) program that is administered by Marion Polk Food Share Meals on Wheels program. Marion Polk Food Share refers to the program simply as the "Senior Grocery Program". We are very excited to provide this service.
The Senior Grocery Program provides 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 (TANF), 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.
For further questions please contact: Marion Polk Food Share Meals on Wheels: 503-364-2856 or email at bbolding@marionpolkfoodshare.org.

Please read pages 1 through 4 before filling out the forms.
Answer all questions and bring copies to the Meals on Wheels office.

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HOW DO I APPLY FOR THE COMMODITY SUPPLEMENTAL FOOD PROGRAM

This application is for the CSFP Program.
To determine if you qualify, you must submit this application to Marion Polk Food Share Meals on Wheels. You must meet certain program requirements to participate in the program. To apply, you must:

Complete this form with all the necessary information; Show proof of statements you make on this form.

Specifically:
- 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 this address 2615 Portland Rd NE (in the Center 50+ building) 503-364-2856 and tell them 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. If 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 Meals on Wheels at this address 2615 Portland Rd NE (in the Center 50+ building) 503-364-2856. 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 Meals on Wheels at this address: 2615 Portland Rd NE (in the Center 50+ building) 503-364-2856. 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.

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.

NUTRITION EDUCATION:

The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants, and will encourage them to participate. The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate.

Commodity Supplemental Food Program: Notice of Beneficiary Rights
Because this program is supported in whole or in part by financial assistance from the Federal Government, we are required to let you know that—

- We may not discriminate against you on the basis of religion or religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice;
- We may not require you to attend or participate in any explicitly religious activities that are offered by us, and any participation by you in these activities must be purely voluntary;
- We must separate in time or location any privately funded explicitly religious activities from activities supported with USDA direct assistance;
- If you object to the religious character of our organization, we must make reasonable efforts to identify and refer you to an alternate provider to which you have no objection.
- We cannot guarantee, however, that in every instance, an alternate provider will be available; and
- You may report violations of these protections (including denials of services or benefits) by an organization to the State agency (FAP.CSFP-TEFAP@state.or.us The State agency will respond to the complaint and report the alleged violations to their respective USDA FNS Regional Office (http://www.fns.usda.gov/fns-regional-offices). You may also contact Oregon Housing & Community Services, Food Program Analyst, 725 Summer St NE, Suite B, Salem, OR 97301-1271, (503) 986-2000.

We must provide you with this written notice before you enroll in our program or receive services from the program, as required by 7 CFR part 16.

Nondiscrimination Statement:

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: http://www.ascr.usda.gov/complaint_filing_cust.html, 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.

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COMMODITY SUPPLEMENTAL FOOD PROGRAM ~CSFP~ REGISTRATION FORM

Today's Date:_____ **Start Date:**_____ **Route#**_____

Your Name:_____ _____

(Last) **(First)** **(M)** **Client #**

Street Address: _____ **- -**

City, State, Zip: _____ **Date of Birth**

Delivery Address Same as Mailing Address ☐ **Yes** ☐ **No**

Phone#: _____ **Gender:** ☐ Female ☐ Male ☐ Other

Number in Household # _____ **Marital Status:** ☐ Married ☐ Single

Total Monthly Income $ **US Veteran:** ☐ Yes ☐ No ☐ spouse of

Do you expect changes in your financial situation or living arrangements in the next few months? If yes, please explain: ☐ Yes ☐ No _____

Source Of Household Income:

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

Complete This Section For All Other Persons In Your Household:

Last, First	Relationship	Date Of Birth

Primary Language _____

Are you Hispanic or Latino? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

☐ I decline to provide this information. 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, LCA or Oregon Food Bank 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.

2615 Portland Rd. NE, Salem, OR 97301 503-364-2856 / foodsharemealsonwheels.org

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- 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.
- The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants and will encourage them to participate.
- The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate.
- 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.

AUTHORIZED REPRESENTATIVE: You can authorize someone outside your household to get your food commodities for you.
By signing this form, I hereby authorize on my behalf regarding the CSFP.

(Name):	**Phone Number:**
Applicant Signature:	**Date**
MPFS-MOW Staff Signature	**Date**

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 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.

FOR OFFICE USE ONLY

I have verified the above information with the client/enrollee

ID Type Provided: _____ _____
Date

☐ Approved ☐ Denied ☐ Notice of Action _____
Date

Notes: ☐ Pick up ☐ Delivery

_____
MPFS-MOW staff initial

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