



Site \_\_\_\_\_

**2024-2025 MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION**

**Eastern Area Agency on Aging, 240 State Street Brewer, ME 04412 1-800-432-7812**

Please complete a separate application for each person enrolling in the program.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_ Is mailbox full or not set up? \_\_\_\_\_

Type of Identification Provided (complete this line in person) \_\_\_\_\_

Ethnicity: Are you Hispanic or Latino? (Response will not influence eligibility)  Yes  No

Race: Please indicate your race(s) using ONE OR MORE: (For civil service statistical purposes only)

- |                                      |                          |  |                          |
|--------------------------------------|--------------------------|--|--------------------------|
| 1) American Indian or Alaskan Native | <input type="checkbox"/> | 2) Asian                                     | <input type="checkbox"/> |
| 3) Black or African American         | <input type="checkbox"/> | 4) Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> |
| 5) White                             | <input type="checkbox"/> |  |                          |

Age: Are you 60 years old or older?  Yes  No

**INCOME:** PLEASE INDICATE YOUR COMBINED MONTHLY INCOME & FAMILY UNIT SIZE IN THE TABLE BELOW

Updated January 17, 2024. This table indicates 130% of the federal poverty line.				
Gross Income for All Members of the Family Unit				
What is your Combined Monthly Income?	Please Check <input checked="" type="checkbox"/> Family Unit Size (Household Size)	Weekly	Monthly	Annual
\$	1 <input type="checkbox"/>	\$376.50	<b>\$1,631.50</b>	\$19,578
\$	2 <input type="checkbox"/>	\$511	<b>\$2,214</b>	\$26,572
\$	3 <input type="checkbox"/>	\$645.50	<b>\$2,797</b>	\$33,566
\$	4 <input type="checkbox"/>	\$780	<b>\$3,380</b>	\$40,560
\$	For each add'l household member, add...	\$135	<b>\$583</b>	\$6,994

How many persons live at your address and make up your family unit? \_\_\_\_\_

Is your household income **LESS** than the amount listed in the above table?  Yes  No

**YOUR RIGHTS AND RESPONSIBILITIES IN THE MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

**I AGREE TO:**

- Provide proof of my income, address, and identification *if requested*.
- Give staff correct information about my current household and its income.
- Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

**I UNDERSTAND THAT:**

- CSFP will provide supplemental foods.
- The CSFP local agency will provide information on other nutrition, health, or assistance programs, and make referrals as appropriate.
- The CSFP local agency will provide nutrition education to all program participants and will encourage participation.
- I will be dropped from this program if I participate in another CSFP.
- I have the right to appeal through the fair hearing process any decision made by the local agency regarding denial,

disqualification, or termination from the program.

- If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program if there is a waiting list.
- I may be taken off the program if I sell or barter with CSFP foods.
- I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- Improper use or receipt of CSFP benefits because of dual participation or other program violations may lead to a claim against you to recover the value of the benefits. It may also lead to disqualification from CSFP.

**CERTIFICATION: The following statement must be read by, or to, the applicant or caretaker before signing.**

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Any questions please contact the agency that provided this application.**

STAFF USE ONLY:	
<u>Certifying Action Taken</u>	
Approved _____	For period ending last day _____
ID Verified in person _____	Date Put on Waiting list if necessary _____
Denied _____	Letter of Fair Hearing Given _____
Date _____	Signature of Verifying & Determining Official _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[Program.Intake@usda.gov](mailto:Program.Intake@usda.gov)

This institution is an equal opportunity provider.