Senior Nutrition & Wellness APPLICATION

Location ____________
Date _________
New/Recert _____

*Do not complete this application if your household has applied for or received CSFP/SNW benefits at another distribution site.

Applicant(s)				
Name	Sex	Date of Birth	Age	CSFP Eligible
1.				
2.				

Address: ____
City, State, Zip: ____

Phone:

Email:

Household Members

List name and age of each additional household member below

1.	3.
2.	4.

Race and Ethnicity (person 1)

This information is voluntary. If you do not provide this information, it will not affect your eligibility.
What is your ethnic category? (Please mark one) ☐ Hispanic or Latino *or* ☐ Not Hispanic or Latino
What is your race? (Select all that apply) ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

Race and Ethnicity (person 2)

This information is voluntary. If you do not provide this information, it will not affect your eligibility.
What is your ethnic category? (Please mark one) ☐ Hispanic or Latino *or* ☐ Not Hispanic or Latino
What is your race? (Select all that apply) ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

Income Eligibility

CSFP Income eligibility requires the applicant to self-certify the household's gross income. Proof of income, such as bank statements, checks, or other documentation that might have personal information will not be collected, copied or stored in the applicant's file.

The total number of people living in my household is__________. Gross Income cannot exceed________________monthly/yearly.
(Agency completes)

I, the undersigned, certify that my household's current monthly/yearly gross income does not exceed the above listed amount. _____
Initials

Authorized Representative Other Than Self To Pick Up USDA Food

Name: ____ Phone Number: ______________________

Address: ____

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS APPLICATION :

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 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 of Applicant or Responsible Party Date

Senior Nutrition & Wellness APPLICATION

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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.

This institution is an equal opportunity provider.

05/05/2022

Remainder of page to be completed by local agency

VERIFICATION (*Circle and document at least one*):

Resident Verification

Driver's License ________________ Rent Receipt ________________

Utility Bill ________________ Other ____________

Rent/Lease Agreement ________________

BENEFITS APPROVAL:

Benefits Approved For (*List names*):____

____

CERTIFICATION:

Certification Period ____________ ____________
(Not to exceed 12 months)

Denied ________ Reason________________________________

Pending ________ Reason________________________________

Termination ________ Reason________________________________
(Copy of Termination Letter Attached)

I hereby certify that this assessment was made on the basis of information contained within the files of our agency. All eligibility criteria were applied as defined by the State of Nevada, Department of Agriculture, Food & Nutrition Division.

____

Approving Authority (Certifier) Agency Date

RE-CERTIFICATION: **(each re-certification is not to exceed twelve months.)**

Re-Certification Period		Re-Certification Period	
From (date): ________	Certifier's Initials: ________	From (date): ________	Certifier's Initials: ________
To (date): ________	Date Completed: __________	To (date): ________	Date Completed: __________