Form 602002 CSFP Applicant Self-Declaration of Need – Write-In – Form

Participant Name:	**Date of Birth:_____/_____/_____** ***Please provide proof of identification.***		
Street Address:	**Apt #:**	**City:**	**Zip:**
Phone Number:(_____)_____-_____H: ☐ C: ☐	**E-mail Address:**		**Door Dash**

What is your TOTAL household income? $_____How many people LIVE in your household? _____

Household Income Reported is received [check one] ☐ Annual ☐ Monthly ☐ Weekly

2024-2025 CSFP Income Guidelines – 150% of Federal Poverty Income Guidelines

Household Size	Annual	Monthly	Weekly
1	$23,475	$1,957	$452
2	$31,725	$2,644	$611
3	$39,975	$3,332	$769
4	$48,225	$4,019	$928
5	$56,475	$4,707	$1,087
6	$64,725	$5,394	$1,245
7	$72,975	$6,082	$1,404
8	$81,225	$6,769	$1,563
For each additional household member, add:	$8,250	$688	$159

For listing of additional household members, please turn over.

Are you Hispanic or Latino [check only one]? Yes ☐ No ☐	**What is your race [check all that apply]?** ☐American Indian or Alaska Native ☐Asian ☐White ☐Black or African American ☐Native Hawaiian or Another Pacific Islander

"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 of ☐ Participant / ☐ Caretaker [check one]:_____

Print Name of Caretaker:_____Signature of Caretaker:_____

Site Name:_____ Site Representative Signature:_____

Date:__/___/____County:_____Link2Feed Barcode or Client ID #:_____

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: USDA Program Discrimination Complaint Form Instructions, 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:

   US Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independent Avenue, SW
   Washington, DC 20250-9410; or

2. Fax:
   (833)256-1665 or (202)690-7442; or

3. Email:
   Program.intake@usda.gov

This institution is an equal opportunity provider.

Additional Household Members			
Household Member	**First Name**	**Last Name**	**Date of Birth**
2			
3			
4			
5			