

SOUTHERN CALIFORNIA TRIBAL CHAIRMEN'S ASSN.
 FOOD COMMODITY PROGRAM
 P O BOX 1326
 VALLEY CENTER, CA 92082
 PHONE: (760) 749-5608
 FAX: (760) 749-7700

OFFICIAL USE ONLY:
 DATE REC'D: _____
 CASE NO: _____
 ELIG.MEM: _____

APPLICATION FOR FOOD COMMODITIES

INSTRUCTIONS: Complete the following information. If you refuse to cooperate/provide verification, your application will be denied. You must provide verification of all income and allowable deductions.

NAME _____ Telephone Number _____

Mailing Address _____
 (Street or P O Box)

(City) _____ (State) _____ (Zip Code) _____

Residence Location _____
 (You are required to provide proof of residency, i.e., SDG&E, Dish Network/ Directv bill or a letter from tribal hall of the reservation you live on).

List each household member, **including you**. All persons who live and eat with you (except roomers and boarders) should be listed as household members. You may be required to provide social security cards for each household member.

HOUSEHOLD MEMBERS:

NAME	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Do you, or does anyone in your household, receive Cal Fresh/Food Stamps? Yes _____ No _____

Date when you last received Cal Fresh/Food Stamps _____ Amount? _____

(Note: The names of household members on this application will be provided to Administrators of the Health and Human Services Agency as required by the U. S. Department of Agriculture).

INCOME FROM WORK: List and fill in all information for each member of household that is employed with a full-time or part-time job. If member has more than one job, list each job separately. We will need at least one recent copy of each member's pay stub(s) or other form of income verification. (Do not include self-employed household members).

HOUSEHOLD MEMBER	NAME OF EMPLOYER	GROSS AMOUNT OF CHECK	HOW OFTEN PAID?
1.			
2.			
3.			
4.			

SELF-EMPLOYMENT INCOME: Name: _____ Amount: _____ How often: _____

Is anyone in your household self-employed? Yes ___ No ___

If yes, please provide a self employment income statement and/or bring last year's Federal tax forms for self-employed members of your household. If no such tax forms were filed last year, bring proof of self-employment costs and income.

UNEARNED INCOME – We will need a recent copy of each household member's check or award letter. TANF, VA Benefits, GA Benefits, Per Capita, Unemployment, SSI, Social Security, Pension, Disability/Workmen's Comp, Child Support, Money from relatives, Foster Care/Adoption Assistance, Alimony, etc.

<u>Source of Income</u>	<u>Household members who receive this income</u>	<u>Amount of each check or payment</u>	<u>How often received?</u>
1. _____	_____	\$ _____	_____
2. _____	_____	\$ _____	_____
3. _____	_____	\$ _____	_____
4. _____	_____	\$ _____	_____
5. _____	_____	\$ _____	_____

STUDENTS: Are there any students in your household who receive education grants, scholarships or loans?

YES _____ NO _____ If yes, you will need to provide verification of loan/grant amount.

ALLOWABLE DEDUCTIONS: Verification will be required.

Dependent Care: Does anyone in your household pay someone to baby-sit or care for a child or a disabled adult so that a member can get to work or training, or look for a job? If yes, we will need verification from the provider of this care (payment receipt, letter, etc.) YES _____ NO _____
 If yes, how much do you pay? _____ How often? _____ Provided by who? _____

Medical Expenses: Is there someone in your household who is at least 60 years old and/or disabled that incurred out-of-pocket medical expenses in excess of \$35? If so, complete the following and bring proof of payment.
 Name of Person who incurred expense: _____
 Amount of Medical Expenses: _____

Shelter/Utility Expense: Do you pay for shelter and utility costs monthly? YES _____ NO _____
 If yes, who do you pay? _____
 (Acceptable proof of verification is utility bill, rent receipt, etc.)

Child Support: Is anyone in your household court ordered to pay child support for a non household member?
 YES _____ NO _____ If yes, Amount ordered to pay \$ _____ Amount actually paid \$ _____

RACIAL-ETHNIC HERITAGE: This is voluntary. If you do not provide this information, it will not affect your eligibility.

American Indian or Alaska Native

White

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

Ethnicity:

Hispanic or Not Hispanic

AUTHORIZED REPRESENTATIVE: You can authorize someone outside your household to get your food commodities for you. If you would like to authorize someone, please write the person's name(s) below:

1. _____
 2. _____
 3. _____
-
-

PENALTY WARNING: If your household receives USDA foods, it must follow the rules listed below. Failure to comply with these rules may result in a monetary claim being filed against the household and/or disqualification from participation in the Food Commodity Program.

DO NOT give false information or hide information to get, or continue to get, food distribution commodities. You are required to report any changes to household circumstances within 10 days of the change.

DO NOT trade or sell food distribution commodities.

DO NOT use someone else's food distribution commodities for your household.

I understand the questions on this application. My answers are correct and complete to the best of my knowledge.

I understand that dual participation in both the Food Stamp Program (Cal-Fresh) and the Food Commodity Program is illegal.

I understand that I have to provide documents to prove what I said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the office may contact to obtain this necessary proof.

Your signature _____

Today's Date _____

Witness _____

(if you signed with an X)

RIGHT TO REQUEST FAIR HEARING: You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. You may also continue to receive the same level of benefits pending the outcome of the hearing. Your case may be presented at the hearing by any one you choose.

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, religious creed, disability, age, political beliefs, 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, audiotope, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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.