SOUTHERN CALIFORNIA TRIBAL CHAIRMEN'S ASSN.
FOOD DISTRIBUTION 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 DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

INSTRUCTIONS: Complete the following information. If you refuse to 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 benefits? 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.

Source of Income	**Household members who receive this income**	**Amount of each check or payment**	**How often received?**
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

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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 Distribution 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 Cal-Fresh (Food Stamp) Program and the Food Distribution 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.

I understand that information for myself and the household members listed on this application will be sent to the Department of Public Social Services (DPSS) solely for the purpose of checking my existing eligibility for CalFresh benefits. By signing this application, I consent to the information being shared.

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, 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 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.

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 (833) 620-1071, 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: 1. **mail:** Food and Nutrition Service, USDA, 1320 Braddock Place, Room 334, Alexandria, VA 22314; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or 3. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov This institution is an equal opportunity provider.