PARTICIPANT APPLICATION

Household Information: To be completed by the applicant or authorized representative

Applicant Name (Last, First, Middle Initial):		**Phone Number**:		**Application Date**:	
Street Address (Include Apt # if applicable):		**City**:	**Zip:**	**State**:	**County**:
Date of Birth (MM/DD/YY):	**Current Age**:	**Total Household Gross Income** (before deductions): $____________			
Household Size (Total number of household members, including applicant): ________		☐ Annual ☐ Monthly ☐ Twice Per Month ☐ Every 2 Weeks ☐ Weekly ☐ No Income			

CSFP Income Guidelines 2024 (130% of poverty rate)

I hereby certify that my household income is at or below the following guidelines. ☐ Yes ☐ No

Household Size	Annual Income	Monthly Income	Twice Per Month	Every Two Weeks	Weekly Income
1	$19,578	$1,632	$816	$753	$377
2	$26,572	$2,215	$1,107	$1,022	$511
3	$33,566	$2,798	$1,399	$1,291	$646
4	$40,560	$3,380	$1,690	$1,560	$780
5	$47,554	$3,963	$1,981	$1,829	$915
6	$54,548	$4,546	$2,273	$2,098	$1,049
7	$61,542	$5,129	$2,564	$2,367	$1,184
8	$68,536	$5,712	$2,856	$2,636	$1,318
For each additional HH member, add:	$6,994	$583	$291	$269	$135

Ethnic/Racial Data: Optional - Data will not affect consideration of application for assistance. This information is requested solely to ensure compliance with Federal Civil Rights laws.

Ethnic Category (Select one):
Are you Hispanic or Latino?
☐ Yes ☐ No

Racial Category (Select one or more):
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African
☐ Native Hawaiian or Other Pacific Islander ☐ White American

Proxy Information: A proxy is a person the applicant may authorize to pick up the CSFP food packages on their behalf for a specified time period. The proxy must be at least 18 years of age and must bring proof of his/her identification to pick up the CSFP food package. If you would like to designate a proxy, please complete the information below.

Name of Proxy (Must be at least 18 years of age):	**Designated Time Period for CSFP Food Pick Up** (Month/year):

OFFICIAL USE (Local Agency Staff Only)

Eligibility Criteria: ☐ Age ☐ Income ☐ County of Residence Applicant's Identification was Confirmed ☐

Verification Source(s) for Identification, Age and County of Residence: ☐ Driver's License ☐ State-Issued ID ☐ Other ______________

Document Name (If other): ______________________________

Local Agency Staff's Printed Name: ______________________________

Local Agency Staff's Signature ______________________________ Date: ____________

CONTINUE TO BACK

OFFICAL USE (To be completed by Subrecipient Official Only)		
Status: ☐ Eligible (Active List) ☐ Eligible (Waiting List)	**Method of Notification:** ☐ Verbal ☐ Letter	**Date of Notification:**
Initial Certification Period: From to **If applicable: Date Certified as Active from Wait List:**	**Re-Certification Period:** 1. From ________ to ________ 2. From ________ to ________	**Re-Certification Dates of Notification** 1. ____________ 2. ____________
Status: ☐ Ineligible ☐ Discontinued ☐ Disqualified ☐ Terminated	**Date of Written Notification:**	
Ineligible/Discontinued/Disqualified/Terminated-Reason:		
Subrecipient Official's Name (Print): ______________________ **Title:** ______________ **Subrecipient Official's Signature:** ______________________ **Determination Date:** ___________		

"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, 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. 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"

This institution is an equal opportunity provider

Certification: 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 Applicant/Authorized Representative (Circle One): **Date:**

APPLICATION INSTRUCTIONS: Complete application in black or blue ink only.

To Be Completed by the Applicant or Authorized Representative

Applicant Name	List applicant's last name, first name and middle initial.
Telephone Number	List applicant's area code and telephone number.
Application Date:	List the date of application.
Street Address	List applicant's street address and if applicable, apartment number.
City	List applicant's city of residence.
Zip Code	List applicant's zip code.
County	List the applicant's county of residence.
Date of Birth	List applicant's month, day and year of birth.
Current Age	List applicant's age.
Total Household Gross Income and How Often is Received	List the total household gross income (before deductions) and check the box for how often income is received (i.e., weekly, monthly, etc.). If no one in the household receives income, check the No Income box.
Household Size	List the total number of household members, including applicant.
Income Certification	Check either Yes or No to certify the household income is within the allowable guideline limits.
Ethnic & Racial Data	This question is optional for the applicant. Please select one Ethnicity, then select one or more Race categories.
Proxy	Complete only if authorizing an individual to obtain the CSFP food kits on the applicant's behalf. Provide the proxy's name and the time period in which the applicant designates the individual as a proxy.
Certification Statement	Read the certification statement and check either Yes or No.
Signature of Applicant/ Authorized Representative	The person for whom CSFP benefits are being requested must sign the application. If the application is being made by an authorized representative, the authorized representative may sign on behalf of the applicant.
Signature Date	List the date the application is signed.

Official Use - To Be Completed by Local Agency Staff Only

Eligibility Criteria/ Applicant Identification	Once the applicant's eligibility criteria and identification have been verified/confirmed, check all applicable boxes. If any box cannot be checked as applicable, the applicant is not eligible for participation.
Verification Source(s)	Check the applicable box(s) for the verification source(s) used to verify/confirm the applicant's identification, age, and county of residence (i.e., driver's license, State-issued ID, etc.). If Other is checked, list the document name (i.e., passport, birth certificate, Medicare Card, etc.). A Social Security card is not an acceptable source of verification.
Local Agency Staff Printed Name	Print the name of the designated Local Agency staff verifying the information on the application.
Local Agency Staff Signature/Date	Provide the signature of the designated Local Agency staff and date the application is received or taken.

Official Use - To Be Completed by Subrecipient Official Only

Status - Eligible Active, Waiting List	Check the applicable box.
Method of Notification/Date	Check the applicable box and provide the date of notification.
Initial Certification Period	Provide the date of the original certification period.
Re-Certification Period/Date	If applicable, provide the re-certification period and the date the applicant was notified of their re-certification.
Date Certified as Active from Waiting List	If applicable, provide the date the participant was certified as Active from the Waiting list.
Status- Ineligible/Discontinued, Disqualified, Terminated - Reason/Date	Check the applicable box and provide the date the written notification was provided.
Subrecipient Official's Printed Name/Title	Print Name and title of Subrecipient Official.
Subrecipient Official's Signature/Date	The Subrecipient Official making the eligibility/ineligibility determination must sign and provide the date the eligibility/ineligibility determination was made.

Revised 05/23

COMMODITY SUPPLEMENTAL FOOD PROGRAM PROXY FORM

County:__________________ Agency Name:______________________

CSFP Participant Information (Please Print Clearly)	
Name:	Date:

I give permission for_________________________________(name of proxy) to pick up my CSFP kit for the specified time indicated*________________(month/year)

*can be one month only **or** entire 12-month certification period – please specify which.

The person you designate as your proxy must bring proof of his/her identification and this completed form to pick up and sign for your CSFP kit. You are responsible for informing your proxy of food distribution schedules.

I certify that this person (my proxy) is at least 18 years of age.

____ ______________________

Signature of CSFP Participant Date

A copy of this form must be placed in each participant's file.

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, 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.

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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"

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USDA

United States Department of Agriculture

Food and Nutrition Service

1320 Braddock Place
Alexandria VA 22314

DATE: February 6, 2024

SUBJECT: Commodity Supplemental Food Program (CSFP): Income Guidelines for 2024

TO: Regional Directors
Supplemental Nutrition Programs
MARO, MPRO, MWRO,
NERO, SERO, SWRO, and WRO

State Directors
CSFP State Agencies and Indian Tribal Organizations (ITOs)

This memorandum transmits the 2024 Income Guidelines (IGs) for State agencies and ITOs in determining the eligibility of individuals applying to participate in CSFP. These guidelines should be used in conjunction with CSFP regulations, at 7 CFR Part 247, which establish household income limits.

Per 7 CFR Part 247.9(b), to be eligible for the program, individuals must be 60 years of age or older and must have household income at or below 130 percent of the Federal Poverty Income Guidelines (Poverty Guidelines) published annually by the Department of Health and Human Services (HHS). The 2024 IGs in the attached tables contain the maximum income limits by household size to be used for eligibility determinations in CSFP. To establish annual income limits of 130 percent, the Poverty Guidelines are multiplied by 1.30, and the results are rounded up to the next whole dollar. From these results, weekly and monthly income limits are calculated. The first table contains the income limits for households residing in the 48 contiguous States, the District of Columbia, and Puerto Rico. Separate income limits for Alaska and Hawaii are established and published annually by HHS, which are reflected in the second and third tables.

Pursuant to program regulations, CSFP State agencies and ITOs must implement the 2024 IGs immediately upon receipt of this memorandum. The guidelines remain in effect until notification of the CSFP IGs for 2025.

CSFP regulations at 7 CFR Part 247.9(d)(1) define "income" as gross income before deductions for such items as income taxes, employees' social security taxes, insurance premiums, and bonds. Income exclusions are listed in Parts 247.9(d)(2) and (d)(3) and via policy memoranda available online at the Food and Nutrition Service's (FNS) website at http://www.fns.usda.gov/csfp. States and ITOs may also authorize local agencies to consider the household's average income during the previous 12 months and current household income to determine which more accurately reflects the household's status, in accordance with 7 CFR Part 247.9(d)(4).

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State agencies should direct any questions they may have regarding the 2024 IGs to their respective FNS Regional Offices. Regional Offices may contact the Food Distribution Division Policy Branch.

/Signature on File

Sara Olson
Director
Policy Division
Supplemental Nutrition and Safety Programs

Attachment

ATTACHMENT
CSFP INCOME GUIDELINES--2024

48 CONTIGUOUS STATES AND DISTRICT OF COLUMBIA*				
	Federal Poverty Guidelines - 100%	**Elderly - 130%**		
Household Size	Annual	Annual	Monthly	Weekly
1……….	$15,060	$19,578	$1,632	$377
2……….	20,440	26,572	2,215	511
3……….	25,820	33,566	2,798	646
4……….	31,200	40,560	3,380	780
5……….	36,580	47,554	3,963	915
6……….	41,960	54,548	4,546	1,049
7……….	47,340	61,542	5,129	1,184
8……….	52,720	68,536	5,712	1,318
For each add'l household member, add…	5,380	6,994	583	135

ALASKA				
	Federal Poverty Guidelines - 100%	**Elderly - 130%**		
Household Size	Annual	Annual	Monthly	Weekly
1……….	$18,810	$24,453	$2,038	$471
2……….	25,540	33,202	2,767	639
3……….	32,270	41,951	3,496	807
4……….	39,000	50,700	4,225	975
5……….	45,730	59,449	4,955	1,144
6……….	52,460	68,198	5,684	1,312
7……….	59,190	76,947	6,413	1,480
8……….	65,920	85,696	7,142	1,648
For each add'l household member, add…	6,730	8,749	730	169

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HAWAII				
	Federal Poverty Guidelines - 100%	**Elderly - 130%**		
Household Size	Annual	Annual	Monthly	Weekly
1……….	$17,310	$22,503	$1,876	$433
2……….	23,500	30,550	2,546	588
3……….	29,690	38,597	3,217	743
4……….	35,880	46,644	3,887	897
5……….	42,070	54,691	4,558	1,052
6……….	48,260	62,738	5,229	1,207
7……….	54,450	70,785	5,899	1,362
8……….	60,640	78,832	6,570	1,516
For each add'l household member, add…	6,190	8,047	671	155

*CSFP State agencies must implement the adjusted income guidelines for applicants immediately upon receipt.

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