COLORADO
Office of Economic Security
Division of Food & Energy Assistance

Commodity Supplemental Food Program Application

Name of Applicant		
Telephone Number	County	
Physical Address (Street, City, Zip Code)		
Mailing Address (If Different) (Street, City, Zip Code)		
Client Case Number	Applicant's Date of Birth	Total No. Living In Household

Names of Qualifying Household Members	Age	Date of Birth	Case Number

Changes must be reported: participants must report changes in household income or composition within 10 days after the change becomes known to the household.

Indicate the source and amount of current (last month's) income before any deductions, such as taxes and social security. This amount must include income of all household members. "other" income would include commissions; strike benefits, income from trusts, contributions from relatives, etc. If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.

Monthly Household Income	Monthly Amount	Monthly Amount
Gross Salary, Wages		
Social Security		
Public Assistance (Welfare)		
Pensions/Retirement		
Self-Employment		
Unemployment		
Other Income		
Total Household Income		

2020 Income Eligibility Guidelines

Household Size	Senior Maximum **Monthly** Household Income	Senior Maximum **Annual** Household Income
1	$1,383	$16,588
2	$1,868	$22,412
3	$2,353	$28,236
4	$2,839	$34,060
5	$3,324	$39,884
6	$3,809	$45,708
For Each Additional Family Member, Add	$486	$5,824

RACIAL ETHNIC DATA (OPTIONAL)					
Are you of Hispanic or Latino origin? (For statistical purposes only) ☐ **YES** ☐ **NO**					
What is your race? (Select one or more)	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Pacific Islander	White

BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the rogram.
- ✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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; I may not receive CSFP benefits at more than one CSFP site at the same time; and improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me to recover the value of the benefits and may lead to disqualification from CSFP. 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 Guardian	Date
Applicant Signature for Certification from Waiting List	Date

*** * * * * * FOR CERTIFYING AGENCY USE ONLY * * * * * ***

I have verified the following for each applicant. Check all that apply.	Applicant is:	Category:	Is caseload available?
☐ Identification ☐ List type of ID _____ ☐ Age ☐ Place of Residence ☐ Household members	☐ Eligible ☐ Not Eligible	☐ Elderly ☐ Child	☐ Yes ☐ No

Date notice is provided to the applicant.

Certification Period: ⟶ First Month: Last Month:

Certifying Official Signature and Date: