Form 402002 CSFP Applicant Self-Declaration of Need WRITE-IN Form









Name of Partic	ipant:		Must Provide Proof Date of Birth:		☐Male ☐Female ☐Prefer not to say.
Street Address:		Apt#:	City:		Zip:
Phone Number	1	□Cell □Home	Email addres		
The state of the s					
What is your total household income? \$ How many persons live in your household?					
Household Income Reported is Received [Check One]:					
2022-23 CSFP Income Guidelines - Elderly 130% of Poverty					
Household Size			Annual Mon		Weekiy
1.		\$17,667		\$1,473	\$340
		\$23,803		\$1,984	\$458
3		\$29,939			\$576
4		\$36,075			\$694
5.		\$42,211			\$812
6		\$48,347		\$4,029	\$930
7		\$54,483		\$4,541	\$1,048
8		\$60,619		\$5,052	\$1,166
For each add	itional household member, add:	\$6,136		\$512	\$118
Household Member	First Name	Last Name	·	Birthdate	Gender [Circle One]
2					Male or Female
3					Male or Female
4	·				Male or Female
For additional household members turn over:					
Are you Hispanic or Latino? [Check Only One]					
What is your race? [Check All That Apply]					
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □					
"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 [] ²⁰					
Signature of □ Participant / □ Caretaker [Check One]:					
Print Name of Caretaker:					
Proxy 1 – Prin	t Name:	Proxy 1 Sign	Proxy 1 Signature:		Date:
Proxy 2 – Print Name: Proxy 2 Signature:					Date:
Site Name:					County:
Site Representative Signature:					Date: