ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services (DAAS)
Coordinated Hunger Relief Program

APPLICATION FOR BENEFITS

TEFAP CSFP

For DS Use Only:

Date:

Client ID#:

DS:

APPLICANT INFORMATION

Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Number of People in the Household: ______________________

Gender *(Optional)*: Male Female Undisclosed

Marital Status *(Optional)*: Single Married Divorced Separated Widowed Undisclosed Common-Law

Address *(No., Street)*: ______________________

City: ______________________ County: ______________________ State: ______________________

ZIP Code: ______________ Phone Number: ______________________ No Fixed Address/Undisclosed

Housing Type *(Optional)*: Emergency Shelter/Mission/Transitional Evacuee Unhoused Own Home Private Rental Public (Social) housing With Family/Friends Youth Home/Shelter Undisclosed Other

Language *(Optional)*: ______________________

Ethnicity *(Required for CSFP)*: White/Anglo Black/African American Hispanic/Latino Pacific Islander Asian American Indian/Native American Alaska Native/Aleut/Eskimo Middle Eastern/North African Other

Self-identified as *(Optional)*: Disability Undisclosed Veteran Mental Illness N/A Pregnant Postpartum Breastfeeding Other

AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

Proxy's Printed Name(s):

______________________ ______________________ ______________________

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. CSFP Clients: 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

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

Applicant's Name *(Please Print)*: ______________________

Applicant's Signature: ______________________ Date: ______________

See page 2 for EOE/ADA disclosures

HOUSEHOLD MEMBER INFORMATION 1

Last Name: ____________________ First Name: ____________________

Date of Birth: ____________________

Relationship: Spouse Child Parent Sibling Grandparent Other Relative Boyfriend/Girlfriend Friend Undisclosed

Gender *(Optional)*: Male Female Undisclosed

HOUSEHOLD MEMBER INFORMATION 2

Last Name: ____________________ First Name: ____________________

Date of Birth: ____________________

Relationship: Spouse Child Parent Sibling Grandparent Other Relative Boyfriend/Girlfriend Friend Undisclosed

Gender *(Optional)*: Male Female Undisclosed

HOUSEHOLD MEMBER INFORMATION 3

Last Name: ____________________ First Name: ____________________

Date of Birth: ____________________

Relationship: Spouse Child Parent Sibling Grandparent Other Relative Boyfriend/Girlfriend Friend Undisclosed

Gender *(Optional)*: Male Female Undisclosed

APPLICANT IS RECEIVING THE FOLLOWING

Supplemental Nutrition Assistance Program (SNAP)

Commodity Supplemental Food Program (CSFP)

Other *(Specify)*: ____________________

The USDA is an equal opportunity provider and employer • Auxiliary aids and services are available upon request to individuals with disabilities • TTY/TDD Services 7-1-1 • Disponible en español en línea o en la oficina local