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# Welcome to the Senior Grocery Program!



This is a USDA (United States Department of Agriculture) program that is administered by FOOD for Lane County. The USDA refers to this program as the Commodity Supplemental Food Program, and CSFP is an acronym that is used on government forms. FOOD for Lane County will continue referring to the program simply as the Senior Grocery Program. We are very excited to provide this service, and we hope you find it helpful and delicious!

The Senior Grocery Program will provide a monthly box of nutritious staple foods. These foods follow a USDA guideline to provide nutrition necessary to a balanced senior diet. You can expect to receive 35 to 40 pounds of food once a month.

You may qualify for this program if you are living on a limited income and are over the age of 60. There are specific income requirements that must be met to qualify. They are attached to you to see if you qualify. If you receive funds through the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program), Temporary Assistance for Needy Families (TANF), or Medicaid you are automatically eligible for this program without additional income verification; we will need to see verification that you are receiving SNAP, TANF or Medicaid to complete your application.

Before you can begin receiving your monthly food box, we must receive a completed application along with a copy of your photo ID and a copy of a piece of mail. These items are necessary to verify age eligibility and proof of address. The copy of your photo ID will be destroyed after age eligibility is confirmed. You can self-declare your income by writing it on the application form, but you must write it on the form yourself or the application will be considered incomplete.

If you have any questions, please contact the Senior Foods team at Food for Lane County.

Phone: (541) 607-5065

Email: [MOWgroup@foodforlanecounty.org](mailto:MOWgroup@foodforlanecounty.org)

\*FOOD for Lane County is an equal opportunity employer and provider.



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## 2025 CSFP Income Guidelines

<u>People in Home</u>	<u>Annual Income</u>	<u>Monthly Income</u>
1 person	\$20,345	\$1,696
2 people	\$27,495	\$2,292
3 people	\$34,645	\$2,888
4 people	\$41,795	\$3,483
Each Additional Add	\$7,150	\$596

Each member of a household can be qualified separately.

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# APPLICATION FOR THE COMMODITY SUPPLEMENTAL FOOD PROGRAM ~CSFP~

*Please read page 1 and 2 before filling out the form. Answer all questions. Keep pages 1 and 2 for your records. Return pages 3, 4, 5 and 6.*

## **HOW DO I APPLY FOR THE COMMODITY PROGRAM?**

This application is for the CSFP Program. To determine if you qualify, you must submit this application to Food For Lane County. You must meet certain program requirements to participate. This program allows specified nutritional foods and offers information on nutritional needs.

To apply, you must:

- Complete this form with all the necessary information.
- Self-declaration of income or no income.
- Show proof of statements you make on this form, specifically:
  - Proof of residence
  - Picture ID

## **HOW DO I APPLY FOR OTHER PROGRAMS AND SERVICES?**

You must contact Food For Lane County at 541-343-2822 if you want to inquire about other services and programs offered.

## **HEARING RIGHTS FOR THE CSFP PROGRAM ONLY:**

*“Standards for participation in the Program are the same for everyone regardless of race, color, national origin, age, sex, and disabilities; you may appeal any decision made regarding your written denial or termination from the Program. If your application is approved, nutritional education will be made available to you and you are encouraged to participate.”*

If you disagree with denial or termination of assistance, you can request a fair hearing within sixty (60) days of the decision by contacting Food For Lane County. A request for a fair hearing shall be personally presented, either orally or in writing. A request for an information review must include: 1) Name, address and contact phone number, 2) the reason for the grievance, 3) the action of relief sought.

A hearings officer will arrange a date, time and place convenient to both parties. In preparing for the hearing you have the right to examine any documents, including records and regulations that are directly relevant to the hearing. You have the right to be represented by counsel or any other person chosen as your representative. You have the right to a private hearing unless you request a public hearing. You have the right to cross-examine all witnesses. The hearings officer must render a decision within fourteen (14) days of the hearing. If you disagree with the decision of the hearing officer, you may pursue a judicial review.

## **DATA COLLECTION:**

Racial and/or ethnic data collected on this form have no effect on the eligibility determination of the household. Thank you for filling out this form as accurately and completely as possible. The federal government is requesting this information in order to monitor compliance with the federal statutes that prohibit federally assisted programs from discriminating against applicants on this basis. Information obtained will be kept confidential and used for statistical analysis only. Racial and ethnic information is voluntary.

## **NUTRITION EDUCATION:**

The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants and will encourage them to participate. The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate.

Nondiscrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

**This institution is an equal opportunity provider.**

Commodity Supplemental Food Program: Notice of Beneficiary Rights

Because this program is supported in whole or in part by financial assistance from the Federal Government, we are required to let you know that—

- We may not discriminate against you on the basis of religion or religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice.
- We may not require you to attend or participate in any explicitly religious activities that are offered by us, and any participation by you in these activities must be purely voluntary.
- We must separate in time or location any privately funded explicitly religious activities from activities supported with USDA direct assistance.
- If you object to the religious character of our organization, we must make reasonable efforts to identify and refer you to an alternative provider to which you have no objection. We cannot guarantee, however, that in every instance, an alternate provider will be available; and
- You may report violations of these protections (including denials of services or benefits) by an organization to the State agency ([FAP.CSFP-TEFAP@state.or.us](mailto:FAP.CSFP-TEFAP@state.or.us)) The State agency will respond to the complaint and report the alleged violations to their respective USDA FNS Regional Office (<http://www.fns.usda.gov/fns-regional-offices>).

We must provide you with this written notice before you enroll in our program or receive services from the program, as required by 7 CFR part 16.

# COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

STREET ADDRESS (If Different): \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

PHONE #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

COMPLETE THIS SECTION FOR ALL OTHER PERSONS IN YOUR HOUSEHOLD:

LAST NAME	FIRST NAME	RELATIONSHIP	DATE OF BIRTH mm/dd/yyyy

**SELF DECLARATION OF TOTAL MONTHLY INCOME: \$** \_\_\_\_\_

**SOURCE(S) OF HOUSEHOLD INCOME:**

- Social Security
- Social Security Disability
- SSI
- Pension

- Unemployment Insurance
- Employment
- Seasonal Employment
- Foster Children

- General Assistance
- TANF
- Self-employed

**CLIENT CHARACTERISTICS**

- Farm Worker
- Disabled
- Veteran
- Health Insurance

**FINANCIAL SITUATION CHANGES:** Do you expect changes in your financial situation or living arrangements in the next few months?  Yes  No If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

**HEAD OF HOUSEHOLD'S ETHNIC ORIGIN:** Note, where an applicant does not provide this information, the data collector shall through visual observation secure and record the information where possible.

1) Are you Hispanic or Latino?  Yes  No

2) What is your race? (Check all that apply)  American Indian or Alaska Native  Asian  
 Black or African American  White  
 Native Hawaiian or Other Pacific Islander

**AUTHORIZED REPRESENTATIVE:** You can authorize someone outside your household to get your food commodities for you.  
 By signing this form, I hereby authorize (Name): \_\_\_\_\_ Phone Number: \_\_\_\_\_ to provide information to DHS on my behalf regarding the CSFP. I further authorize DHS, LCA and Oregon Food Bank to access any records in order to verify information given.

- I consent to any legally authorized investigation for confirmation of any information that I provide. I agree to let the State of Oregon Department of Human Services give information to DHS, LCA or Oregon Food Bank to determine my eligibility.
- I acknowledge that I have received the first page of this application outlining my rights to request a fair hearing if my application is denied. I understand that I must request a hearing within sixty (60) days of the written date of denial.
- I CANNOT sell or trade commodities or use someone else's commodities for my household.
- I also agree to inform the CSFP office if my household income or composition changes. I will provide the new information within ten (10) days of the change.
- The local agency will make nutrition education available to all adult participants, and to parents or caretakers of infant and child participants, and will encourage them to participate
- The local agency will provide information on other nutrition, health or assistance programs, and make referrals as appropriate
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against the individual to recover the value of the benefits, and may lead to disqualification from CSFP

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 I may not receive both CSFP and WIC benefits simultaneously, and 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.

Yes     No Please indicate your decision by placing a check mark in the appropriate box.

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESSED IF SIGNED WITH AN X: \_\_\_\_\_ DATE: \_\_\_\_\_

STAFF MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>FOR OFFICE USE ONLY:</b>	
ID Type Provided: _____	
<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> NOTICE OF ACTION _____ Date: _____	
Staff Initial _____	
Remarks:	
<b>Annual review of eligibility:</b>	
Participant eligible and interested in participation Y/N    Staff initial: _____ Date: _____	
Participant eligible and interested in participation Y/N    Staff initial: _____ Date: _____	

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## Mutual Respect Policy and Agreement

By participating in the Senior Grocery program, both recipient (you), program staff and volunteers agree to abide by the mutual respect policy.

I agree to:

- Always treat each individual with respect.
- Respect the privacy and confidentiality of all individuals.
- Observe nonviolence in all interactions with the program and support a nonviolent environment for all participants. Nonviolence is a statement of human rights and dignity.
  - A nonviolent environment has no room for sexism, racism, ageism, disrespectful language or physical aggression.
  - A nonviolent environment includes pets. If staff or volunteers will be entering your home or coming to your door, please make sure it is safe for them to do so by restraining any aggressive or unpredictable animals.
- Dress in a way that provides adequate bodily coverage to maintain the comfort and safety of all individuals.
- Make a sincere effort to understand other points of view, by accepting that others have values and opinions that are different from your own - not wrong, different.
- Identify problems or concerns in a respectful way.
  - Do not yell at, blame, threaten, or name call, even if angry, frustrated, or hurt.
  - If there is a problem you have not been able to resolve, seek assistance from the program manager

I, \_\_\_\_\_ agree to the mutual respect policy stated above and acknowledge that my participation in the Senior Grocery program may be discontinued if I violate this agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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# EMERGENCY CONTACT FORM

**YOUR FULL NAME**

\_\_\_\_\_

**PRIMARY EMERGENCY CONTACT**

Full Name		
Relationship		
Contact Number		
Alternate Number		
Email Address		

**SECONDARY EMERGENCY CONTACT**

Full Name		
Relationship		
Contact Number		
Alternate Number		
Email Address		

Emergency contacts are only used in the event we're unable to reach you, the client, after several attempts.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

