



Senior Grocery Program

Thank you for applying to our Supplemental Commodity Food Program. This is a USDA program that is administered by Food for Lane County. The USDA refers to this program as the Commodity Supplemental Food Program (CSFP). Food for Lane County will continue referring to the program simply as the Senior Grocery Program.

You may qualify for this program if you are living on a limited income and are over the age of 60. See page 2 for income requirements. Those that do qualify will receive 35 to 40 pounds of nutritious staple foods once a month.

Please answer all questions. Keep pages 1-4 for your records, return pages 5-8 to Food for Lane County.

Before sending your application in, **please make sure you include the following:**

- ☐ Application fully completed, including your household income*.
**A household includes people you live with AND with whom you share grocery expenses. If you have roommates but only buy groceries for yourself, you would not include them in the household.*
- ☐ A copy of your driver's license, state ID card or passport
- ☐ A piece of mail to verify your address
- ☐ Signed "Mutual Respect Policy" form
- ☐ Emergency Contact form

Please return your completed application to:

Food for Lane County
Attn: Senior Foods Team
770 Bailey Hill Rd.
Eugene, OR 97402

If you have any questions, please contact the Senior Foods team at Food for Lane County.
Phone: (541) 343-7256
Email: SeniorGroceryGroup@foodforlanecounty.org

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

2026 CSFP Income Guidelines

<u>People in Home</u>	<u>Annual Income</u>	<u>Monthly Income</u>
1 person	\$23,940	\$1,995
2 people	\$32,460	\$2,705
3 people	\$40,980	\$3,415
4 people	\$49,500	\$4,125
Each Additional Person Add	\$8,520	\$710

For households with 2 or more people:

- If you share grocery expenses, include everyone's income.
- If you do not share grocery expenses, only list your income.

NOTE: If you do not meet the income requirements above but receive benefits through SNAP, TANF or Medicaid you are automatically eligible for this program. Please include proof of benefits with your completed application.

APPLICATION FOR THE COMMODITY SUPPLEMENTAL FOOD PROGRAM ~CSFP~

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 for 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 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 nutritional 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, 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.

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 based on 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). 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 whether my household income or composition changes. I will provide the new information within ten (10) days of the change.
- The local agency will make nutritional 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 because 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 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: _____

FOR OFFICE USE ONLY:

ID Type Provided: _____

☐ APPROVED ☐ DENIED ☐ NOTICE OF ACTION _____ Date: _____

Staff Initial _____

Remarks: _____

Annual review of eligibility:

Participant eligible and interested in participation Y/N Staff initial: _____ Date: _____

Participant eligible and interested in participation Y/N Staff initial: _____ Date: _____

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 everyone 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 are 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 _____

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 _____