Texas Department of Agriculture

Form H1504
April 2010

Commodity Supplemental Food Program (CSFP)

Participant Application

Household Information — To be completed by Applicant/Household Member/Authorized Representative or Recipient Agency that is determining eligibility.

Name of Applicant (Last, First, Middle Initial)	Site Name	Date of Birth
Address (Street, City, State, ZIP Code)	Area Code and Telephone No. – –	Gender Male Female

Have you ever received food from the Commodity Supplemental Food Program? .... Yes No

If yes, where?

Date applicant last received food from the CSFP:

Do you currently receive benefits from the Special Supplemental Program for Women, Infants and Children (WIC)? .... Yes No

If yes, what was the referral date?

Total Number of Household Members	Total Gross Income (before deductions) of all Household Members $ Weekly Monthly Yearly	**Note:** SNAP benefits do not count as income.

Race: Black or African American ☐ Asian or Pacific Islander ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Certification

Form H1504 is 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 have been advised of my rights and obligations under the Program, including the right to appeal any decision made by the local agency regarding my denial or termination from the Program. I understand that the local agency will make nutrition education available to me and I am encouraged to participate. I understand that participating in WIC and the CSFP at the same time is not allowed and will result in being removed from at least one Program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

Ineligibility

I have been advised in writing that I am ineligible to participate in the Commodity Supplemental Food Program and have the right to a fair hearing. I am ineligible to participate based on the following criteria:

Income Residency Category WIC

Signature—Applicant	Date	Name of Proxy—Optional (print or type)

Nondiscrimination

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call 202-260-1026, 866-632-9992 (toll-free), or 202-401-0216 (TTD). “USDA is an equal opportunity provider and employer.”

To be completed by program staff — Initial Application

Eligibility

Income Yes No
- Social Security
- Pay Stub
- Income Tax Return
- Bank Statement

Categorical Yes No

Residence Yes No

WIC Yes No

Category

- Woman (pregnant or breastfeeding, infant)
- Estimated delivery date ______________
- Infant age 0 through 3 months
- Infant age 4 through 11 months
- Child age 1 through 3 years
- Child age 4 through 5 years
- Postpartum woman
- Actual delivery date ______________
- Elderly
- Not categorically eligible

Determination

- Eligible
- Not Eligible
- Eligible – On Waiting List

Determination Date ______________

Date of Initial Visit ______________

Certification Period

______________ – ______________

____
Signature—Individual Making Determination

____
Title—Individual Making Determination

Recertification — To be completed by program staff only.

Name of Applicant (Last, First, Middle Initial)	Site Name	Date of Birth
Address (Street, City, State, ZIP Code)	Area Code and Telephone No. – –	Gender Male Female
Total Number of Household Members	Total Gross Income (before deductions) of all Household Members $ Weekly Monthly Yearly	**Note:** Food Stamps do not count as income.

Eligibility	Category	Determination
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