DATE REVIEWED: _____

POKAGON BAND OF POTAWATOMI FOOD DISTRIBUTION PROGRAM APPLICATION FORM

(269) 782-3372 · 888-281-1111 · Fax-269-782-7814

THE CERTIFICATION WORKER can assist you with this application or you may complete it at home and bring it in or mail it to this office.
IF YOU CANNOT FILL OUT THE APPLICATION, another member of your household or an adult who knows you may complete the form and return it to us.
OR THE CERTIFICATION WORKER will help you with it at the time of interview.
WHEN YOU COME FOR THE INTERVIEW please bring proof of all household income. For example, pay stubs, or **AN AWARD LETTER** for government or public assistance benefits (SSI, Social Security, Pension, ADC, GA, ETC.). We may also need statements of all household savings, savings accounts, and dependent care costs.

YOUR NAME_____SS#_____PHONE#_____

ADDRESS_____CITY_____

COUNTY_____STATE_____ZIP_____

PLEASE LIST MEMBERS OF YOUR HOUSEHOLD **(INCLUDE YOURSELF)**
(DO NOT LIST ROOMERS OR BOARDERS)

NAME	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY #
_____	**self**	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INCLUDE THE SOCIAL SECURITY OF EACH FAMILY MEMBER WHO HAS ONE. THIS WILL HELP US TO IDENTIFY YOUR HOUSEHOLD CORRECTLY. THE SOCIAL SECURITY NUMBERS MAY ALSO BE USED IN PROGRAM REVIEWS OR AUDITS TO MAKE SURE YOUR HOUSEHOLD IS ELIGIBLE FOR FOOD DISTRIBUTION. WE ARE AUTHORIZED TO ASK FOR THIS INFORMATION UNDER THE TAX REFORM ACTS OF 1976.

INCOME FROM WORK

List each member of your household (over age 18) who has a full-time or part-time job. If a member has more than one job, list each job separately. List any members who receive pay from CETA or WIN. DO NOT LIST SELF-EMPLOYED MEMBERS.

ATTACH VERIFICATION OF WAGES (MOST CURRENT 3 PAY STUBS)

Household members name employer gross amount each paycheck how often paid

1. _____

2. _____

3. _____

4. _____

State the amount of pay BEFORE deductions such as taxes, child support garnishments and retirement or union dues are taken out.

SELF-EMPLOYED PERSONS: IF YOU, OR SOMEONE IN YOUR HOUSEHOLD, ARE SELF-EMPLOYED, ASK FOR A SELF-EMPLOYMENT FORM. WE WILL NEED TO SEE TAX FORMS OR MONTHLY RECEIPTS OF PAYMENT AS PROOF OF INCOME.

INCOME FROM OTHER SOURCES

SOURCE OF INCOME	MEMBERS RECEIVING	AMOUNT OF EACH CHECK	HOW OFTEN PAID
AFDC (Aid to families with dependent children)	_____	_____	_____
GA (General Assistance)	_____	_____	_____
Social Security (blue/green checks)	_____	_____	_____
SSI (Supplemental Security) Income-gold checks)	_____	_____	_____
VA (Veterans Benefits)	_____	_____	_____
Pension or retirement	_____	_____	_____
Unemployment Compensation	_____	_____	_____
Child support/Alimony	_____	_____	_____
Money from relatives or friends (NOT LOANS)	_____	_____	_____
Any other (PER CAP)	_____	_____	_____

DEPENDANT CARE COSTS

Does someone in your household pay someone to baby sit, care for a child, or a disabled adult, so that a household member can go to work, training or look for work?
If so, and the provider is a (**licensed**) care provider a deduction is allowable for your household's total income.
NAME OF PERSON PROVIDING CARE_____
ADDRESS_____

PHONE
NUMBER_____
AMOUNT PAID AND HOW OFTEN (DAILY, WEEKLY, MONTHLY)_____
_____

AUTHORIZED REPRESENTATIVE

You may authorize someone outside of your household to pick up your food commodities for you.
NAME_____

YOUR RACIAL ETHNIC HERITAGE: (Optional)

You are not required to provide this information; your cooperation will help determine compliance with Federal Civil Rights laws. IN NO INSTANCE WILL THIS INFORMATION BE USED IN CONSIDERATION OF YOUR APPLICATION. IF YOU CHOOSE NOT TO ANSWER IT WILL IN NO WAY EFFECT CONSIDERATION OF YOUR APPLICATION. We are authorized to ask for this information under Title VI of the Civil Right Act of 1964.

_____ American Indian _____ Black- not of Hispanic origin _____ Hispanic

_____ Asian/Pacific Islander _____ White-not of Hispanic origin

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REPORTING REQUIREMENTS

Certified households are required to report the following changes within 10 days of the date the change becomes known to the household:

1. **Changes in income that would affect program eligibility.**
2. **All changes in household composition, such as the addition or the loss of a family member.**

PENALTY WARNING:

If your household receives food commodities, you must follow the rules below:

1. **Do not give false information, or hide information to receive or continue to receive food commodities. For example: it is unlawful to participate in the food stamp (SNAP) program and the commodities program simultaneously in the same month.**
2. **Do not trade or sell food commodities.**
3. **Do not use someone else's information for commodities for your household.**

I understand the questions and statements on this application. My answers are correct and complete to the best of my knowledge.

I understand that I may have to provide documentation to prove what I have stated. I agree to do this. If documentation is not available, I agree to give the office the name of a person or organization to contact to obtain the necessary proof.

YOUR SIGNATURE_____ **TODAY'S DATE**_____

WITNESS (If you sign with an X) _____

You and your representative may request a fair hearing either orally or in writing, if you disagree with any action taken on your case. Any person you choose may present your case at a hearing.
WE WILL CONSIDER THIS APPLICATION WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.

Interview Date: _____

Person Interviewed_____

Please read and sign:

I UNDERSTAND I CANNOT RECEIVE COMMODITY FOODS AND FOOD STAMPS (SNAP) IN THE SAME MONTH. TO DO SO IS ILLEGAL AND CAN SUBJECT ME TO POSSIBLE FRAUD CHARGES BY THE TRIBE, OR DEPT OF SOCIAL SERVICES. I WILL TAKE EITHER COMMODITY FOODS OR FOOD STAMPS BUT NOT BOTH.

IN THE EVENT YOU WISH TO SWITCH FROM FOOD COMMODITIES TO FOOD STAMPS YOU MUST NOTIFY US SO WE CAN DEACTIVATE YOUR CERTIFICATION WITH OUR PROGRAM.

IF YOU ARE CURRENTLY RECEIVING FOOD STAMPS AND WISH TO RECEIVE FOOD COMMODITIES FROM US, YOU MUST CONTACT THE FAMILY

INDEPENDENCE AGENCY FROM WHOM YOU ARE RECEIVING FOOD STAMPS TO BE DEACTIVATED.

UPON DEACTIVATION WE WILL NEED WRITTEN NOTICE FROM THE DEPARTMENT OF HUMAN SERVICES BEFORE ISSUING FOOD COMMODITIES TO YOU.

YOUR SIGNATURE:

_____

DATE: _____

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at: http://www.ascr.usda.gov/complaint_filinf_cust.html or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or e-mail at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm

USDA is an equal opportunity provider and employer.

YOU ARE RESPONSIBLE TO INFORM THE FOOD DISTRIBUTION PROGRAM IF YOU SHOULD DECIDE TO CHOOOSE SNAP FOR AN UPCOMING MONTH, INSTEAD OF COMMODITIES, AT LEAST (10) DAYS IN ADVANCE OF SAID MONTH.