



Grocery Plus Enrollment Application

Commodity Supplemental Food Program & Senior Farmers' Market Nutrition Program



Site Name _____

First Name _____ **M.I.** _____ **Last Name** _____

Street Address _____ **Apt** _____

City _____ **State** _____ **Zip** _____ **Ward** _____

Home Phone _____ - _____ - _____ **Email** _____

Cell Phone _____ - _____ - _____

Please check one: New enrollee Reenrolling

What is your gender? Male Female

Select your ethnicity (Choose only one): Hispanic/Latino Not-Hispanic/Latino

Select your race (You can choose more than one): American Indian or Alaska Native Asian

Black or African American Native Hawaiian or Other Pacific Islander White

Date of Birth: _____ / _____ / _____

How many people live full-time in your home? _____

Gross Household Income: \$ _____ **Frequency:** Weekly Monthly Annually

When I am unable to pick up my Grocery Plus (CSFP) box or when, in season, my yearly senior farmers' market nutrition program vouchers (SFMNP), I give permission to the persons listed below.


Proxy Name _____ **Proxy Phone Number** _____
 Home Cellular

Proxy Name _____ **Proxy Phone Number** _____
 Home Cellular

I understand that the CSFP/SFMNP foods are for my benefit, and no one else.


Compliance Agreement

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 that I may not receive CSFP/SFMNP benefits at more than one CSFP/SFMNP 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?

Please indicate decision by placing a checkmark in the appropriate box. Yes No

Applicant Signature _____ **Date:** _____

 Do you authorize the Capital Area Food Bank to send phone call reminders regarding Grocery Plus distributions, important changes, or updates to your status in the program? Yes No

Consent to Participate in the DC SNAP-Ed Text Message Program: By indicating below, I authorize DC SNAP-Ed to send me text messages. I understand that message/data rates may apply to messages sent by DC SNAP-Ed under my cell phone plan. I agree not to hold DC SNAP-Ed, DC Health, or DC Government liable for any electronic messaging charges or fees generated by this service. I may opt-out of receiving these communications at any time by replying STOP to DC SNAP-Ed text messages. By affirming below, I indicate I am the person legally responsible for all use of this mobile account, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging program. As part of the program, we may be asking for your feedback at various points to help us improve the program for you and other seniors.

Do you wish to participate in the DC SNAP-Ed Text Message Program: Yes No

Signature _____ **Date:** _____

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, audiotope, 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, (AD3027) 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.

This Section Must Be Completed by Site Leaders Only:

Document Verification

Form of ID (must prove birthdate/age) Reminder: Applicant must be 60 or over

Driver's License Birth Certificate State Issued ID Other _____

Proof of Residency (may be the same as ID) Reminder: Applicant must be DC resident.

Driver's License Bill with current address Lease Other _____

By signing below, I affirm that I have reviewed the application and source documents. I attest that the information regarding the applicant's identity, age and residency was verified and is accurately recorded on this document.

Signature _____ **Date** _____

Site Name _____ **Zip** _____ **Ward** _____

This Section Must Be Completed by CAFB Grocery Plus Staff Only

Application Certification

Status: Approved Date _____ Waitlisted Date _____ Denied Date _____

Method of Notification Verbal / Telephone / Letter **Notification Date** ____ / ____ / ____

Reviewed by _____ **Date** ____ / ____ / ____



Grocery Plus

Healthy Food for Seniors



Important Information about Participating in Grocery Plus

- Enrollment into Grocery Plus (CSFP) is valid for a period of three years. While you will not be asked to fill out a new application each year, you will be expected to do a “recertification” every year.
- Every year during “recertification” you will be asked if your income information, name and home address are still up-to-date. You will also be asked if you still wish to be enrolled in the CSFP program, and if you wish to enroll in the Senior Farmers’ Market Nutrition Program (SFMNP). If you have information to update you will be able to do so. If you do not complete recertification you will be removed from Grocery Plus (CSFP and SFMNP).
- You **may be removed** from the CSFP program if you do not pick-up your Grocery Plus box for three months in a row.
- You or your proxy **must bring ID** and **sign** the roster each month when you pickup your Grocery Plus (CSFP) box of food.
- You need to update the CAFB when your phone number or address changes, within 10 days of the change occurring.
- You may be removed from the program if you threaten or physically abuse a CAFB staff or volunteer.
- Due to high demand and a limited caseload, new enrollees are placed on a waitlist at the site where they enroll.
- If you are on a Waitlist for the program, you are not guaranteed a monthly Grocery Plus (CSFP) food box, but you may be contacted to receive a box in the case there are unclaimed food boxes that month. You also may be contacted to pick up annual Senior Farmers’ Market Nutrition Program vouchers.
- Waitlisted participants will be notified when they move from the Waitlist onto the active roster of a site.
- If you have authorized the Capital Area Food Bank to do so, you may receive calls regarding the distribution times of your site and updates about changes regarding your distributions or your eligibility in the program.

If you have any questions, please call (202) 644-9880 to speak with a staff member.

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