

**COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)
 CERTIFICATION AND FOOD PACKAGE PICK-UP (MOTHERS & CHILDREN)**

Participation in CSFP is voluntary. Personally identifiable information collected is required for participation and will be used for that purpose only.

Last Name of Participant (Please print)	First Name	MI	Date of Birth	County	CSFP ID Number
Street Address	Apt.	City	Zip Code	Telephone	Date Certification Begins Date Certification Ends
Parent/Proxy Last Name (Please print)	Parent/Proxy First Name	Relationship	WIC Clinic		
Full Name of Second Proxy (Please print)	Full Name of Third Proxy (Please print)				

I certify with my signature that:

- my gross household income is at or below the federal poverty guidelines for this program for the number of people in my household as indicated on this form.
- I will use the federal commodities received for the above-named participant only.
- I release the USDA/FNS, the State of Wisconsin and any agency or person distributing federal commodities from any liability resulting from receipt of this food.
- I understand that giving false information may result in my having to reimburse the State for the value of food improperly issued to me and may subject me to criminal prosecution under State and Federal law.
- rules for acceptance and participation in the program are the same for everyone without regard to race, color, national origin, age, sex or disability.
- reasonable accommodations may be requested to participate in this program.

This application is being completed in conjunction 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 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. (Please indicate your decision by placing a checkmark in the appropriate box.) YES NO

Race (check all applicable)	SIGNATURE – Recipient of Food	Date Signed	Staff Initials	Other Program Information Given
<input type="checkbox"/> American Indian or Alaska Native	1.			
<input type="checkbox"/> Asian	2.			
<input type="checkbox"/> Black or African American	3.			
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	4.			
<input type="checkbox"/> White	5.			
Ethnicity (check one)	6.			
<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	7.			
Stamp income guidelines here	8.			
	9.			
	10.			