



www.spectrumgenerations.org

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3/3/2010

Spectrum Generations will be starting a new program in Northern Kennebec, Southern Kennebec and Androscoggin County that would provide low-income people 60 years and older with about 30 pounds of food each month for free. A typical month may include foods such as: pasta, tuna, peanut butter, etc.

This program is still in the planning stages and may not happen, but we wanted to give you the opportunity to get in on the ground floor. Please understand that while we are hopeful that we'll be able to start the program, there are no guarantees.

If you would like to be a part of this "Food Bank" please sign this letter to reserve your space on the program.

Please note this project is designed for you to pick up the food at specific locations in, Lewiston, Augusta and Winslow. Please DO NOT sign up if you are NOT able to pick up the food! You may have a signed person as a proxy pick up for you but must do so every month.

Please sign below that you agree with the following statement:

"I understand that my signature does not guarantee that I will receive food from the new proposed Food Bank. My signature ONLY signifies my interest in the program. If the program is NOT developed, I will not hold Spectrum Generations responsible."

Signature

Date

Print Name

Town

Please fill out the enclosed form and return with this signed letter to the appropriate location below. We will let you know **WHEN** this program

William S. Cohen Community Center Phone: 626-7777
Attn: Lynda Johnson, Nutrition Coordinator (Southern Kennebec & Androscoggin County)
22 Town Farm Road
Hallowell, ME 04347

Muskie Community Center Phone: 873-4745
Attn: Ryan Poirier, Nutrition Coordinator (Northern Kennebec County)
38 Gold Street
Waterville, ME 04901

Belfast
Waldo Community
Center

Damariscotta
Coastal Community
Center

Hallowell
William S. Cohen
Community Center

Rockland
Knox Community
Center

Skowhegan
Somerset Community
Center

Topsham
Spectrum
Generations

Waterville
Edmund S. Muskie
Community Center

MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM APPLICATION
Please complete a separate application for each person you are enrolling on the program.

Name _____ Date of Birth _____

Address _____ City _____ ZIP _____

County _____ Home Phone _____ Work Phone _____

Please indicate ONE OR MORE: (For civil service statistical purposes only) Are you . . .

1) American Indian or Alaskan Native
 Yes No

2) Asian
 Yes No

3) Hispanic or Latino
 Yes No

4) Black or African American
 Yes No

5) Native Hawaiian or Other Pacific Islander
 Yes No

6) Caucasian
 Yes No

IS THE APPLICANT:

- Is the applicant 60 years old or older? Yes No
- Is the applicant currently receiving any benefits under the WIC (Women, Infants, & Children) Program? Yes No
- Is the applicant living with a friend or relative? Yes No

INCOME:

Gross Income for all Members of the Family Unit					
Current Income Limits based upon Federal Guidelines for the following period:			July, 1, 2009 to June 30, 2010		
Family Unit Size	Weekly	Bi-Weekly	Semi-Monthly	Monthly	Annual
1	\$273	\$546	\$587	\$1,174	\$14,088
2	\$367	\$734	\$790	\$1,580	\$18,960
3	\$461	\$922	\$992	\$1,984	\$23,808
4	\$556	\$1,112	\$1,195	\$2,389	\$28,668
5	\$650	\$1,300	\$1,398	\$2,795	\$33,540
6	\$744	\$1,488	\$1,600	\$3,199	\$38,388

How many persons live at your address and make up your family unit? _____

Is the applicant's gross family unit income less than the amount listed above? Yes No

Has the applicant been on CSFP before? Yes No

Is the applicant currently receiving CSFP? Yes No

**YOUR RIGHTS AND RESPONSIBILITIES IN THE
MAINE COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

I AGREE TO:

- Provide proof of my income, address, and identification if requested.
- Give staff correct information about my current household and their income.
- Let staff know if my address, income or household composition changes or if I plan to move within 10 days.

I UNDERSTAND THAT:

- CSFP will provide supplemental foods.
- CSFP will provide referrals to nutrition, health or assistance programs as appropriate.
- The CSFP local agency will provide nutrition education to all program participants.
- I will be dropped from this program if I participate in another CSFP or WIC Program.
- I have the right to appeal through the fair hearing process, any decision made by the local agency regarding denial, disqualification, or termination from the program.
- If I do not pick up food 2 months in a row, without telling staff, I will be taken off the Program.
- I may be taken off the program if I sell, trade, or give away CSFP foods.
- I may be taken off the program if I intentionally make false or misleading statements, orally or in writing.
- I may be taken off the program for intentionally withholding information pertaining to eligibility in CSFP.
- I may be taken off the program if I physically abuse or threaten to physically abuse program staff.
- Improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against you to recover the value of the benefits, and may lead to disqualification from CSFP.

CERTIFICATION

This application form 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 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.

Yes **No** 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.)

By reading, signing and dating this form, I acknowledge that I have been advised of my rights and obligations under the program. I attest that the information provided is accurate and complete and that I am not receiving any WIC benefits. I understand that I may not receive WIC and CSFP benefits at the same time and that I must notify CSFP of all changes of income, address or household composition within 10 days.

Signature: _____

Date: _____

In accordance with Federal law and U.S. Department of Agriculture policy, program standards are applied without discrimination by race, color, national origin, sex, sexual orientation, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY).

STAFF USE ONLY:

Certifying Action Taken

Approved _____ For period ending last day _____

Date Put on Waiting list if necessary _____

Denied _____ Letter of Fair Hearing Given _____

Date _____ Signature of Verifying & Determining Official _____