

YUROK FOOD DISTRIBUTION PROGRAM



Instructions: Complete the following information. If you **refuse to cooperate or provide verification**, your application will be denied. You must provide proof/verification of all income and allowable deductions.

Name (Head of Household): _____ County: _____
 Mailing Address: _____ Household Size: _____
 Street Address: _____ Phone No.: _____
 City/State/Zip: _____
 Directions to Your Home: _____

HOUSEHOLD MEMBERS: Complete the following for each member of your household. Your household means yourself and the people who live/eat with you. Do not include boarders. List your name first. (Attach a separate sheet if you need to list additional household members.)

Name(s) of all Household Members (Last, First, Middle Initial) Please Print	Relationship to Head of Household	Date of Birth	Email (optional)
1.	SELF		
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you or anyone in your household currently receiving SNAP (Food Stamps) benefits?

Yes No If yes, list names: _____

Have you or anyone in your household recently applied for SNAP (Food Stamp) benefits?

Yes No If yes, list names, date applied and outcome: _____

Have you or anyone in your Household been disqualified from SNAP for an Intentional program violation?

Yes No If yes, list names: _____

OFFICE USE ONLY:

Called county office of _____ on ___/___/___ and spoke to _____

SNAP/SSI Verified by: _____

INCOME: List income from all sources for each Household member including wages, social security, SSI, TANF, general/public assistance, foster care payments, unemployment or worker's compensation, child support, alimony, pensions, Veteran's benefits, per capita payments from gambling enterprises, work/training allowances, etc. **Verification is required for all household members who receive income (Check stubs, SSI award letters, ETC.)** Households are required to provide the past 30 days of income. Attach a separate sheet if you need to list additional household members.

HOUSEHOLD MEMBER	EMPLOYER/SOURCE OF INCOME	TYPE OF INCOME (Wages, social security, TANF, child support, ect)	GROSS AMOUNT	HOW OFTEN PAID Monthly, bi-weekly, weekly

SELF-EMPLOYMENT INCOME: Are there any members in your household who are self-employed?
 YES NO If yes, complete the following section.
 Payments from rental property, roomers, boarders, farming, ranching, and/or operating your own business are considered to be self employment. Please provide a copy of last year's Federal Income Tax form (1040, Schedules F, C, E, if applicable, or other proof of self-employment costs and income (current books showing income and expenses).

HOUSEHOLD MEMBER	TYPE OF BUSINESS (Farm, ranch, Rental, Day Care, ETC.)	OCCUPATION	Is this your primary source of Income for meeting your living expenses?

STUDENTS: Are there any students in your Household who receive education grants, scholarships or loans?
 YES NO
 If Yes, please complete the following section. Please provide verification.

HOUSEHOLD MEMBER	AMOUNT OF LOAN/GRANT	PERIOD OF TIME FUNDS INTENDED TO COVER	TYPE OF PAYMENT (Pell Grant, Student Loan, BIA)	Amount used to pay Tuition/School Fees/Other related expenses.

ALLOWABLE DEDUCTION (Please provide verification):

STANDARD SHELTER/UTILITY EXPENSE: Does anyone in your household pay, on a monthly basis, at least one shelter/utility expense?

Yes No If yes, type of Shelter/Utility expense paid monthly: _____

DEPENDENT CARE: Does anyone in your household pay for the care of a child or other dependent when necessary for a household member to accept or continue employment or to attend training or pursue education which is preparatory to employment?

Yes No If yes: Name and address of person providing care: _____

Amount Paid: _____. How often paid (weekly, monthly, ECT): _____

CHILD SUPPORT: Does anyone in your household pay court ordered child support for a non household member?

Yes No If yes, complete the following:

Amount ordered to pay: \$_____ Amount actually paid: \$_____ How often _____

EXCESS MEDICAL EXPENSES: Anyone in your household elderly and/or disabled?

Yes No If yes, complete the following:

Monthly total of medical expenses: _____. Do not include expenses from special diets.

AUTHORIZED REPRESENTATIVE: To authorize someone outside of your household to act on your behalf and/or pick up your food, complete this section.

NAME(S)	ADDRESS	PHONE NUMBER

RACIAL/ETHNIC DATA:

1. What is your ethnic category? Hispanic or Latino **or** Not Hispanic or Latino
2. What is your race? American Indian or Alaskan Native Asian White
 Black/African American Native Hawaiian or Pacific Islander

FAIR HEARING: If you disagree with any action taken on your case, you or your representative have the right to request a fair hearing. You may request a fair hearing in writing or orally. If you request a fair hearing, your case may be presented by a household member or representative, such as legal counsel, a relative, a friend or other spokesperson.

PENALTY WARNING: If your household receives USDA food benefits, it must follow the rules below. Failure to comply with these rules may result in a monetary claim being filed against the household and/or disqualification from participation in the Food Distribution Program.

1. Do not make false or misleading statements, misrepresent, conceal, or withhold facts regarding income, household size, and/or participation in the Supplemental Nutrition Assistance Program (SNAP) in order to obtain Food Distribution benefits which your household is not entitled to receive.
2. Do not misuse (trade, sell, ETC.) USDA foods
3. Do not participate simultaneously in the Supplemental Nutrition Assistance Program (SNAP) and the Food Distribution Program.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: If you or any member of your household knowingly and willingly violates the rules above it is considered an Intentional Program Violation (IPV). Household members determined to have committed an IPV will be ineligible to participate in the Food Distribution Program for a period of 12 months for the first violation, for a period of 24 months for the second violation; and permanently for the third violation. Individual(s) committing an IPV may be referred to authorities for prosecution.

AUTHORIZATION TO RELEASE INFORMATION: All adult household members must sign.			
I authorize the release of any necessary information or forms to the Food Distribution Office from individuals, businesses, schools, banking institutions, Federal/State/Tribal agencies needed to determine/verify my eligibility. I understand that this information will be used only for the purpose of helping to document my eligibility for Food Distribution benefits. This authorization is good for 12 months from the date signed or until revoked by me in writing.			
Printed Name	Date of Birth	Signature	Date Signed

CERTIFICATION STATEMENT: I certify that I have read this application and that the information contained in it is true and correct to the best of my knowledge. I understand that I must comply with Program rules and provide additional documentation if required, and that falsification of information on this form may be grounds for disqualification and/or claim action. I further understand that I must report within **10 calendar days** after the change becomes known the following changes: a change in household size or composition; an increase in monthly income of more than \$100; a change in residence/address; when the household no longer incurs a shelter or utility expense; or a change in the legal obligation to pay child support.

APPLICANT’S SIGNATURE: _____ **DATE:** _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
FNCSIVILRIGHTSCOMPLAINTS@usda.gov

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