ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Community Assistance and Development (DCAD)
Coordinated Hunger Relief Program

APPLICATION FOR BENEFITS

○ TEFAP ○ CSFP

For DS Use Only:
Date:
Client ID#:
DS:

APPLICANT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Number of People in the Household: _____

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Marital Status *(Optional)*: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Undisclosed ☐ Common-Law

Address *(No., Street)*: _____

City: _____ County: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Housing Type *(Optional)*: ☐ Emergency Shelter/Mission/Transitional ☐ Evacuee ☐ Unhoused ☐ Own Home ☐ Private Rental ☐ Public (Social) housing ☐ With Family/Friends ☐ Youth Home/Shelter ☐ Undisclosed ☐ Other ☐ No Fixed Address/Undisclosed

Language *(Optional)*: _____

Ethnicity *(Required for CSFP)*: ☐ White/Anglo ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Asian ☐ American Indian/Native American ☐ Alaska Native/Aleut/Eskimo ☐ Middle Eastern/North African ☐ Other

Self-identified as *(Optional)*: ☐ Disability ☐ Undisclosed ☐ Veteran ☐ Mental Illness ☐ N/A ☐ Pregnant ☐ Postpartum ☐ Breastfeeding ☐ Other

AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

Proxy's Printed Name(s):

_____ _____ _____

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. CSFP Clients: 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

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

Applicant's Name *(Please Print)*: _____

Applicant's Signature: _____ Date: _____

See page 3 for USDA/EOE/ADA disclosures

HOUSEHOLD MEMBER INFORMATION 1

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Other Relative
☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

HOUSEHOLD MEMBER INFORMATION 2

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Other Relative
☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

HOUSEHOLD MEMBER INFORMATION 3

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Other Relative
☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

APPLICANT IS RECEIVING THE FOLLOWING

○ Supplemental Nutrition Assistance Program (SNAP)

○ Commodity Supplemental Food Program (CSFP)

○ Other *(Specify)*: _____