

Riverside-San Bernardino County Indian Health Inc.

Food Distribution Program

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THE FOLLOWING ITEMS MUST BE VERIFIED IN ORDER TO DETERMINE IF YOU ARE ELIGIBLE FOR THE COMMODITY FOOD PROGRAM:

1. Identification for ALL household members: You must provide social security card, birth certificates/baptismal certificates for all household members. Tribal enrollment card may be required for identity.
2. Verify of Your Income: You must provide income verification for ALL household members that has been received in the last 30 days from the date of your application. THIS INCLUDES PER CAPITA OR REVENUE SHARING PAYMENTS. Check stubs, award letters or direct deposit statements will be accepted.
3. Verify Your Residency: You must live on a reservation in our food program service area or within 20 miles from one of our service area reservations, in a town with the population under 10,000. We are able to serve certain areas over population limit due to program waivers but you must check with us first to see if your area qualifies. Verification can be a recent utility bill, bank statement or a letter from the tribal administration. (For those who live in the right area but not on a reservation, see #4 below).
4. If you do not reside on a service area reservation, you must be a member of a FEDERALLY RECOGNIZED TRIBE and must provide proof. (Such as a tribal card or BIA statement).
5. If anyone in your household is age 60 and older or disabled and you pay more than \$35 a month for medical expenses, we can deduct this amount when you provide verification of amount to us.
6. If you pay shelter and utility costs per month, we are able to take standard deduction for these costs when they are verified.

THE FOOD DISTRIBUTION PROGRAM IS A LOW INCOME PROGRAM. Your household's total income must be below the income limit for your household size.
HOUSEHOLD MEMBERS WHO RECEIVE FOOD STAMPS ARE NOT ELIGIBLE FOR THE PROGRAM.

APPLICATION FOR FOOD COMMODITIES

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

Name _____ Telephone Number _____

Mailing Address _____
 (Street or PO BOX)

(City) _____ (State) _____ (Zip Code) _____

Residence Location _____

(You are required to provide proof of residency: i.e. utility bill, recent bank statement or a letter from tribal hall/administration of the reservation you live on).

List each household member including yourself. All persons who live and eat with you (except roomers and boarders) should be listed as household members. You must provide social security cards for each household member.

HOUSEHOLD MEMBERS:

NAME	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSEHOLD	SOCIAL SECURITY #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Do you or anyone in your household receive Cal Fresh/Food Stamps? Yes _____ No _____
 Date when you last received Cal Fresh/Food Stamps _____ Amount _____

(Note: The names of household members on this application will be provided to Administrators of the Health and Human Services Agency as required by the U.S. Department of Agriculture).

INCOME FROM WORK: List and fill in all information for each member of household that is employed with a full-time or part-time job. If member has more than one job, list each job separately. WE will need each members pay stubs or other form of income verification received in that last 30 days. (Do not include self-employed household members).

HOUSEHOLD MEMBER	NAME OF EMPLOYER	GROSS AMOUNT OF CHECK	HOW OFTEN PAID?
1.			
2.			
3.			
4.			

SELF-EMPLOYMENT INCOME:

Is anyone in your household self-employed? Yes _____ No _____

If yes, please provide a self-employment income statement and/or bring last year’s federal tax forms for self-employed members of your household. If no such tax forms were filed last year, bring proof of self-employment costs and income.

UNEARNED INCOME: We will need a recent copy of each household members check or award letter. TANF, VA Benefits, GA Benefits, Per Capita, Unemployment, SSI, Social Security, Pension, Disability/Workmen’s Comp, Child Support, Money from relatives, Foster Care/Adoption Assistance, or Alimony etc.

SOURCE OF INCOME	HOUSEHOLD MEMBER WHO RECEIVES THIS INCOME	AMOUNT OF EACH CHECK/PAYMENT	HOW OFTEN RECEIVED?
1.			
2.			
3.			
4.			
5.			

Students: Are there any students in your household who receive education grants, scholarships or loans? Yes _____ No _____

If yes, you will need to provide verification of loan/grant amount.

ALLOWABLE DEDUCTIONS: Does anyone in your household pay someone to baby-sit or care for a child or a disabled adult so that a member can get to work, training or look for a job? If yes, you will need verification from the provider of this care (payment receipt, letter etc.) Yes _____ No _____

If yes, how much do you pay? _____ How often? _____ Provided by who? _____

MEDICAL EXPENSES: Is there someone in your household who is at least 60 years old and/or disabled that incurred out-of-pocket medical expenses in excess of \$35? If so, complete the following and bring proof of payment.

Name of person who is incurred expense: _____

Amount of medical expenses: _____

SHELTER/UTILITY EXPENSES: Do you pay for shelter and utility costs monthly? Yes _____ No _____

If yes, who do you pay? _____

(Acceptable proof of verification is utility bill, rent receipt, etc.)

CHILD SUPPORT: Is anyone in your household court ordered to pay child support for a non-household member? Yes _____ No _____

If yes, Amount ordered to pay \$ _____ Amount actually paid \$ _____

RACIAL-ETHNIC HERITAGE: This is voluntary. If you do not provide this information, it will not affect your eligibility.

American Indian or Alaska Native Hispanic/Latino Asian Black or African American

Native Hawaiian or Other Pacific Islander White

AUTHORIZED REPRESENTATIVE: You can authorize someone outside your household to get your food commodities for you. If you would like to authorize someone, please write the person's name(s) below:

1. _____
2. _____
3. _____

PENALTY WARNING: If your household receives USDA foods, it must follow the rules listed 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 Commodity Program.

- DO NOT give false information or hide information to get or continue to get food distribution commodities.
- DO NOT trade or sell food distribution commodities.
- DO NOT use someone else's food distribution commodities for your household.
- I understand the questions on this application. My answers are correct and complete to the best of my knowledge.
- I understand that dual participation in both the Food Stamp Program (Cal-Fresh) and the Food Commodity Program is illegal.

I understand that I have to provide documents to prove what I said. I agree to do this. If documents are not available, I agree to give the name of person or organization the office may contact to obtain the necessary proof.

Your Signature _____ Date _____
Witness _____

(If you signed with an X)

RIGHT TO REQUEST FAIR HEARING: You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. You may also continue to receive the same level of benefits pending the outcome of the hearing. Your case may be presented at the hearing by any one you choose.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for 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, audiotape, 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 (800) 877-8339. Additionally, program information may be available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/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) 623-9992. Submit your complaint 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.

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ZERO INCOME STATEMENT

IF YOU HAVE ZERO INCOME FOR THE PAST 30 DAYS, YOU MUST ANSWER THE FOLLOWING QUESTIONS:

- 1) How is your rent being paid? _____
- 2) How are your utilities being paid? _____
- 3) How are you providing food for your household? _____
- 4) Are you receiving any money from family or friends? Yes___ No___ How much? _____
(You must verify any income)
- 5) Are you currently looking for work? _____
- 6) Have you applied for TANF, CASH AID or General Assistance (GA)? _____
- 7) If you are residing with other people (family or friends) do you purchase, prepare and eat food separately? _____

I hereby certify that the information I have provided accurately represents the total income for EACH member of my household 18 years of age or older.

SIGNATURE _____

DATE _____