Missoula Food
Bank 219 S. Third
St. West Missoula,
MT 59801
Phone (406) 549-0543

Dear Potential ROOTS Recipient:

Thank you for your interest in receiving food from Missoula Food Bank through our ROOTS-Senior Delivery Program. Missoula Food Bank and the Department of Health and Human Services partner to deliver a free, nutritious monthly food package to seniors.

Each package we deliver contains juice, cereal or oatmeal, boxed and dry milk, peanut butter or dry beans, rice or pasta, chili or stew, cheese, canned fruits and vegetables and a supplement of Ensure and fresh fruit or vegetables. Inventory options are limited but will try to accommodate special dietary needs you may have.

To qualify for this program, you must:

1. Be 60 years of age or older

2. Meet income guidelines outlined on the next page.

The income information you supply is completely SELF-DECLARED: accordingly, we will not investigate your income or personal information.

Please complete both sides of the application form, make your food choices, and return the application to Missoula Food Bank. If you have any questions about the application itself, program eligibility or the services in general, please do not hesitate to call Jessy at (406)549-0543 ext. 110.

Finally, if you find you are either not eligible or not interested in being a client, please help us to pass on this information to others who may qualify and wish to benefit from the program. We are also always looking for VOLUNTEERS!

Sincerely,
Missoula Food Bank Staff

This project is funded (in part) under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the department.

2016 Elderly Income Guidelines

130% OF POVERTY INDEX

CSFP FINAL FFY 2016 ELDERLY INCOME GUIDELINES						
	FEDERAL POVERTY	CSFP ELDERLY ELIGIBILITY GUIDELINE - 130% OF POVERTY				
HOUSEHOLD SIZE	2016 GUIDELINES ANNUAL	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$11,880	**$15,444**	$1,287	$644	$594	$297
2	$16,020	**$20,826**	$1,736	$868	$801	$401
3	$20,160	**$26,208**	$2,184	$1,092	$1,008	$504
4	$24,300	**$31,590**	$2,633	$1,316	$1,215	$608
5	$28,440	**$36,972**	$3,081	$1,541	$1,422	$711
6	$32,580	**$42,354**	$3,530	$1,765	$1,629	$815
7	$36,730	**$47,749**	$3,979	$1,990	$1,837	$918
8	$40,890	**$53,157**	$4,430	$2,215	$2,045	$1,022
For each add'l family member, add..........	$4,160	**$5,408**	$451	$225	$208	$104

based on the US Department of Health and Human Services Annual Update of the Poverty Guidelines as published in the Federal Register #81 FR 4036, pages 4036-4037, Document #2016-1450

DPHHS-FD-034
(Revised 01/16)

STATE OF MONTANA
Department of Public Health and Human Services

DATE:____________

ELDERLY CSFP APPLICATION

Applicant ____
(Last Name) (First Name) (Middle Initial)

Address____
(Number) (Street) (City) (Zip) (County)

Contact Phone:____________________________Email:_____________________________________

☐ **ID VERIFIED & TYPE OF ID**: ☐ **Drivers License** ☐ **Birth Certificate** ☐ **SSN** (Don't record SSN#)

☐ **Alternate ID (Specify)**:________________________________

Other Program Participation that meets CSFP eligibility criteria? ☐ Yes - Program:_______________☐ No

Number of People in Household Including Applicant:_______________

Household Members:	Age:	Date of Birth:	Relationship:

RACIAL/ETHNIC DATA COLLECTION REQUIREMENT:
What is your ethnic category?: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
What is your race? (Select one or more): ☐ American Indian or Alaskan Native ☐ Asian
Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

HOUSEHOLD INCOME: (Total Must Not Exceed 130% of the Current Federal Poverty Level Guidelines)

SOURCE OF INCOME	AMOUNT RECEIVED	HOW OFTEN RECEIVED
Wages, Salary		
Social Security		
Public Assistance (Welfare)		
Pension/Retirement (non-SS)		
Self-Employment		
Unemployment		
Other (Specify)		
Other (Specify)		
TOTAL HOUSEHOLD INCOME		

INCOME COMPLETION DIRECTIONS: Income should be as current as possible (previous month's) Indicate source, amount and how often received (weekly, monthly, bi-weekly, quarterly, annually) Income before deductions such as taxes and SS. MUST INCLUDE INCOME OF ALL HOUSEHOLD MEMBERS. If income inconsistently received then project it on an annual basis. "Other, Specify" could be income from commissions, strike benefits, income from trusts, contributions from relatives, etc.
SNAP BENEFITS (Food Stamps) do not count as income.

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. I am aware I may not receive CSFP benefits at more than one CSFP site at the same time. I am also 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.

Please see reverse side of this form.

DPHHS-FD-034 (Revised 1/16) **State of Montana CSFP Elderly Application - page 2**

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

______________________________ (SIGNATURE OF APPLICANT)   ______________________________ (DATE)

- *You will be notified of your eligibility, eligibility and placement on a waiting list, or ineligibility within 10 days of receipt of this correctly completed and signed application by the local CSFP agency.*
- *You may appeal any decision made by the local agency regarding your denial or termination from the program. You have a right to a fair hearing.*
- *If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.*

THE FOLLOWING AUTHORIZED INDIVIDUALS MAY TO ACT AS MY REPRESENTATIVE FOR CSFP:

NAME______________________________ RELATIONSHIP TO APPLICANT________________

NAME______________________________ RELATIONSHIP TO APPLICANT________________

IF INELEGIBLE PLEASE STATE REASON:____

____

NEW CERTIFICATION: ID VERIFIED:______ ELIGIBLE________ NOT ELIGIBLE________

CERTIFICATION DATE FROM______________________TO________________________

TITLE OF CERTIFIER_______________SIGNATURE__________________________DATE_________

2ND CERTIFICATION : ID VERIFIED:_______ ELIGIBLE________ NOT ELIGIBLE________

CERTIFICATION DATE FROM______________________TO________________________

TITLE OF CERTIFIER_______________SIGNATURE__________________________DATE_________

Every Six Month Review Requirement: CLIENT CONTACT BY PHONE_________ IN PERSON________

CLIENT WISHES TO REMAIN ON CSFP FOR A CONSECUTIVE SIX MONTHS? ____________________

NEW ADDRESS (IF CHANGED)____

CIVIL RIGHTS STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior 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 at (800) 877-8339. Additionally, program information may be made 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/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) 632-9992. Submit your completed 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.

This institution is an equal opportunity provider.

FOOD CHOICES

(subject to availability).

1. CHOOSE ONE:

- ☐ Cold Cereal (2 packages) **or**
- ☐ Farina (2 packages) **or**
- ☐ Oatmeal (1 package)

2. CHOOSE ONE:

- ☐ Beef Chili (1 can) **or**
- ☐ Beef Stew (1 can)

3. CHOOSE ONE:

- ☐ Peanut Butter **or**
- ☐ Dry Beans

4. CHOOSE ONE:

- ☐ Spaghetti (2 lbs) **or**
- ☐ Macaroni (2lbs) or
- ☐ Rice (2 lbs)

Everyone will receive:
2 bottles of Juice, 2 lbs of Cheese, Liquid Milk, Dry Milk (every other month), 2 cans of Fruit, and 4 cans of vegetables!

Note: This is a federal program and we are required to deliver all of your food. If you receive an item you do not care for, or cannot use, please pass on to a friend, neighbor, or give back to your driver at your next delivery. Thank you.