COLVILLE CONFEDERATED TRIBES
FOOD DISTRIBUTION PROGRAM APPLICATION

P.O. BOX 150 NESPELEM, WA. 99155
(509) 634-2767, 634-2766, 634-2770

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

Name (Head of Household): _____ County: _____

Street Address: _____ Household Size: _____

City/State/ZipCode: _____ Telephone No.: _____

Directions To Your Home: _____

HOUSEHOLD MEMBERS: Complete the following for each member of your household. Your household means yourself and the people who live with you. 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 *(self, spouse, daughter, son, cousin etc.)*	DATE OF BIRTH	SOCIAL SECURITY #
1.			
2.			
3.			
4.			
5.			
6.			
7			
8.			
9.			

***Are you or anyone in your household currently receiving SNAP benefits?** ☐ **Yes** ☐ **No** If yes, list names: _____

***Have you or anyone in your household recently applied for SNAP benefits?** ☐ **Yes** ☐ **No** If yes, list names: _____

***Have you or anyone in your household been disqualified from the Supplemental Nutrition Assistance Program (SNAP) for an intentional program violation?** ☐ **Yes** ☐ **No.** If yes, list name(s): _____

INCOME (EARNED & UNEARNED): 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 of income is required for all household members (pay check stubs, award letters, etc.). Households with earned income must provide a full month's wage statements. 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, etc.)	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. Payment from rental property, roomers, boarders, farming, ranching, and/or operating your own business is 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 your self-employment the 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, 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 Rel. Exp.

ALLOWABLE DEDUCTIONS [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, etc.) _____

***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: $ _____

***EXCESS MEDICAL EXPENSES: Anyone in your household elderly and/or disabled? ☐ Yes ☐ No**
If yes, complete the following: Monthly total of medical expenses, excluding special diets: $_____

***RACIAL/ETHNIC DATA COLLECTION:** *This information is voluntary*. If you do not provide this information, it will not affect your eligibility.

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 ☐Black or African American
   ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, religious creed, disability, age, political beliefs, 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: How to File a Complaint, 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.

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

NAME(S)	ADDRESS	TELEPHONE NUMBER

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 with the Food Distribution Program Manager – Dorothy Palmer. If you request a fair hearing, your case may be presented by a household member or representative, such as a legal counsel, a relative, a friend or other spokesperson.

PENALTY WARNING: If your household receives USDA foods, 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, resources, household size, and/or participation in the Supplemental Nutrition Assistance Program (SNAP) in order to obtain Food Distribution Program benefits which your household is not entitled to receive.**
2. **Do not misuse (e.g., trade or sell) 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 willing 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: 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.

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 ten (10) calendar days after the change becomes known the following:

1] a change in household size or composition;
2] an increase in gross monthly income of more than $100;
3] a change in residence/address;
4] when the household no longer incurs a shelter or utility expense;
5] or a change in the legal obligation to pay child support.

Applicant's Signature _____ **Date** _____