APPLICATION FOR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATION

FOR OFFICE USE ONLY
CASE # _____
DATE RECEIVED: _____

KLAMATH TRIBES COMMODITY PROGRAM
1625 Martin St.
KLAMATH FALLS, OR 97601
(541) 883-2876
FAX: 883-6505

IMPORTANT: When you are interviewed, please bring proof of all household income. For example: pay stubs, award letters, Social Security. We may also need statements of all household savings-checking accounts, utility bill and dependent care costs. We must have Proof of a Tribal Affiliation. Commodities will not be issued until all requested documentation is provided.

Check List:

☐ **Verification of income for ALL household members for the last 30 days.**
If receiving social security, we must have a copy of your entire award letter that states which program you receive your funds from. (SSI/SSD and so on).* ***Bank statements will not work*.

☐ **Zero income form**

☐ **Dependent Care Costs**

☐ **Utility bill and/or rent receipt**

☐ **Proof of Tribal affiliation**

☐ **Proof of address (if you provided a utility bill that will have the proof of address on it)**

INTENTIONAL PROGRAM VIOLATIONS: An intentional program violation is considered to have occurred when a household member knowingly, willingly, and with deceitful intent:

1. Make a false or misleading statement, or misrepresents conceals, or withholds facts in order to obtain Food Distribution Program benefits that the household is not entitled to received; or
2. Commits any act that violates a Federal statute or regulation relating to the acquisition or use of Food Distribution Program commodities.
3. **You will not receive commodity food if you are receiving food stamps.**

Revised 11/223

Only the household member determined to have committed the IPV will be disqualified – not the entire household.

Name _____

Mailing Address (include city/zip): _____

Residence Address: _____

Phone number: _____

Household Size: _____

PENALTIES

Household members determined by the ITO/State agency to have committed an IPV will be ineligible to participate in the program:

1. For a period of 12 months for the first violation;
2. For a period of 24 months for the second violation; and
3. Permanently for the third violation.

Are you or anyone in your household currently receiving food stamps? Yes ☐ No ☐

If yes, list names _____

If your food stamp case is open or in suspense, we will not be able to approve your application and issue commodities until the following month.

Have you or anyone in your household recently applied for food stamps? Yes ☐ No ☐

Have you or anyone in your household been disqualified for an intentional program violation under the Food Stamp Program?

Yes ☐ No ☐ If yes, list name: _____

HOUSEHOLD MEMBERS: Complete the following for each member of the household. Your household means yourself and the people who live with you. List your name first. (Attach a separate sheet if needed for additional household members).

NAME(S) OF HOUSEHOLD MEMBERS First/Middle/Last	RELATIONSHIP TO HEAD OF HOUSEHOLD	DATE OF BIRTH	APPLYING FOR COMMODITIES Y/N	PREPARE MEALS TOGETHER Y/N
1)	**SELF**			
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

IN ORDER TO ISSUE COMMODITIES TO YOUR HOUSEHOLD, WE MUST HAVE PROOF OF A TRIBAL AFFILIATION, PROOF OF YOUR ADDRESS AND PROOF OF ALL HOUSEHOLD INCOMES.

INCOME: List income from employment salary for all household members.
You must provide proof of income for the *last 30 days*. Include **full and part-time employment**, Plus those who receive income from JTPA or Win.

Enter the Gross (before taxes and deductions) salary.

NAME	TYPE & SOURCE	AMOUNT	HOW OFTEN
		$	
		$	
		$	

Other Income (unearned)

Income from **social security**, **retirement**, **SSI** (supplemental security income**) veterans benefits**, **unemployment**, **GA** (general assistance) or **TANF**, **Foster Care** (DHS payments), alimony, child support, bonds, savings, and payments from government per capita.

You must provide proof of ALL income sources.

NAME	TYPE & SOURCE	AMOUNT	HOW OFTEN
		$	
		$	
		$	

SELF EMPLOYMENT INCOME: You must attach copies of your last years Federal income tax form, if available or proof of self-employment costs and income:

NAME	TYPE & SOURCE	AMOUNT	HOW OFTEN
		$	
		$	

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Multiply weekly income by 4.3
Multiply bi-weekly by 2.15
Multiply twice a month by 2

Total Gross Income

1) $_____

Multiply line 1 by .80
(Earned income deduction)

2) $_____

Total Unearned Income

3) _____

Add line 2 and 3
4) _____

Total Gross Self-Emp.

5) $_____

Multiply line 5 by .80
(Earned income deduction)
Total Self Employment

6) $_____

Total Education Income
7) $_____

Subtract Edu. Expenses of

STUDENT INCOME: Grants, Scholarships, and Loans.

NAME	TYPE & SOURCE	AMOUNT	HOW OFTEN
		$	
		$	

STUDENT EXPENSES: ONLY TUITION OR MANDATORY FEES.

NAME	TYPE & SOURCE	AMOUNT	HOW OFTEN
		$	
		$	

ALLOWABLE DEDUCTIONS (Please provide verification for all deductions)

1. **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 expense paid monthly: _____
   (Must provide proof/ copy of bill)

2. **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:

   Name_____ **Amount Paid:** $_____
   (Must provide proof/ receipts)

   How often paid (weekly, monthly, etc.) _____
   Contract workers who may have a partial year contract (6, 9, 10 months) will have Their total salary averaged over a 12-month period per USDA regulations.

3. **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 offered to pay: $_____Amount actually paid: $_____
   (Must provide proof/ court order)

4. **EXCESS MEDICAL EXPENSES**: Anyone in your household elderly and /or

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Total from line 10
11) $_____

12) Total standard deduction (Deduction $450)

Subtract line 12 from 11 if marked yes
13) $_____

Dependent care
14) $_____

Child Support
15) $_____

Excess Medical Expenses
16) $_____

Home Care Meal
17) (Standard deduction $192)

Add line 14, 15, 16, and 17
18) $_____

Subtract line 18 from 13
19) $_____

HOUSEHOLD SIZE
_____

Disabled? Yes □ No □ If yes, monthly total medical expenses, *excluding* special diets: $_____

(Must provide proof/ receipts)

5. **HOME CARE MEAL:** Does your household furnish a majority of meals for a home care attendant? Yes □ No □ Name of attendant _____

AUTHORIZED REPRESENTATIVE:

To authorize someone outside your household to pick up your food or prepare your application forms, complete the information below. Commodities will not be released to any other person if not on the authorization list.

NAME(S)	ADDRESS	TELEPHONE NUMBER
1)		
2)		
3)		

FAIR HEARING: If you disagree with any action taken on your household's case you or your representative may request a fair hearing in writing or orally. Your case may be presented by any person you choose.

RACIAL/ETHNIC HERITAGE: Title VI of the Civil Right Act of 1964 allows us to ask for racial/ethnic information. You do not have to give this information; however, providing this information will help us follow the Federal Civil Rights Law. If you do not provide this information, it will not affect your case.

□ American Indian or Alaskan Native □ White □ Black □ Asian or Pacific Islander □ Hispanic Origin

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 report any changes in household size or income/resources within ten days of the date the change becomes known. I hereby authorize the Commodity Program Staff to verify my income, checking account, public assistance or AFDC grants and other financial or eligibility criteria.

Applicant's Signature _____ **Date:** _____

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 discrimination 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.

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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 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.)

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HOUSEHOLD DETERMINATION:

[ ] DENIED- REASON _____
[ ] APPROVED
[ ] Categorically eligible
[ ] Expedited service
[ ] Meets income guidelines
[ ] Household not participating in SNAP
[ ] Verified Social Security
[ ] Household informed of rights and responsibilities

Household Size: _____
Certification Period: _____

Certifier's Signature: _____

FY 2024 NET MONTHLY INCOME STANDARDS

1	**$1,413**
2	**$1,842**
3	**$2,270**
4	**$2,708**
5	**$3,173**
6	**$3,636**
7	**$4,064**
8	**$4,493**
Each additional member	**$429**

Effective October 1, 2023 to September 30, 2024