Food Distribution Program Application

Sault Ste. Marie Tribe of Chippewa Indians

3601 S. Mackinac Trail * Sault Ste. Marie, MI 49783
Phone: (906) 635-6076 or 1-888-448-8732
Fax: (906) 635-3658

CASE #: _____

Your Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No. (Contact or Message?) _____ County: _____

Please List All Members of Your Household (Include Yourself & Do not list Roomers or Boarders)
(*Include the Soc. Sec. Number of each family member who has one. We are authorized to ask for this information under the Tax Reform Act of 1976)

NAME (Please Print Clearly)	RELATIONSHIP	BIRTHDATE	SOCIAL SEC. NUMBER

Does anyone in your household currently receive SNAP (Food Stamps) _____ YES _____ NO

Warning: I understand that I cannot receive Food Commodities and SNAP (Food Stamps) in the same month, and to do so is an intentional program violation (Fraud).

_____ _____

Signature **Date**

FOR OFFICE USE ONLY

DHS SNAP Clearance: _____ Active _____ Inactive

Done By: _____ @ _____ Co. DHS Date & Initials: _____

EARNED INCOME: (Please Provide Verification of all Wages)

Household Members Name	Name of Employer	Gross Amt. of Each Paycheck	How Often Paid

UNEARNED INCOME: (Please Provide Verification of all That You Receive)

	Household Member	Amount	How Often
Social Security			
SSI			
TANF (AFDC)			
General Assistance			
Pension/Retirement			
VA Benefits			
Unemployment			
Workmans Comp			
Child Support			
Alimony			
Foster Care			
Money From Friends or Relatives			
Other:			

ODD JOBS: (Please Include Receipts for Each Job)

Household Members Name	Name of whom you worked for	Amt. Paid	How Often

s Anyone in the Household Self Employed? _____ Yes _____ No

If Yes, please provide a copy of the current Profit & Loss Statement from their taxes

---

Is anyone in your household attending a College or University physically or online? ____ YES ____ NO

*If yes please verify your billing statement for the current semester.

DEDUCTIONS (please verify)	Source	Amount Paid	How Often
Child Care			
Child Support			
Shelter			
Utility			
Medicare (out of pocket expense)			

* Medical deductions apply only to 60 and over or disabled, receipts will be required.

AUTHORIZED REPRESENTATIVE: (someone outside of your household)

Print Name:_____ Phone: _____

I authorize this person to: _____ Pick up my commodities _____ Discuss my case

---

Have you ever applied for our program before? _____YES _____ NO

Your Racial-Ethnic Heritage:

Although you are not required to provide this information, your cooperation will help determine compliance with Federal Civil Rights Law. In no instance will this information be used in considering your application. If you decline to provide this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

_____American Indian _____Hispanic _____Black-Not of Hispanic Origin _____White-Not of Hispanic Origin _____Asian or Pacific Islander

Reporting Requirements

Certified households are required to report the following changes within ten (10) business days of the date the change becomes known to the household, such as:

1. Changes in income that would effect program eligibility
2. All changes in household composition, such as the addition or loss of a family member

Penalty Warnings

If your household receives food distribution, it must follow the rules below:

2. Do NOT give false information, or hide information to get (or continue to get) commodities
3. Do NOT trade or sell food distribution commodities
4. Do not use someone else's food distribution commodities for your own household

Fair Hearing

You and your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose. Please call 1-888-448-8732 or (906) 635-6076 for more information.

Civil Rights Notice

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 retalitation 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.

SIGNATURE

I understand the questions and statements on this application. My answers are correct and complete to the best of my knowledge. I understand that I may have to provide documents to verify what I have said, and I agree to do so. If documents are not available, I agree to give the office the name of a person or organization to contact to obtain the necessary verification.

Your Signature: (and/or witness if signed with an X) _____ Date: _____