ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services (DAAS)
Coordinated Hunger Relief Program

For DS use only:

Date:

Client ID#:

DS:

○ TEFAP ○ CSFP

APPLICATION FOR BENEFITS

APPLICANT INFORMATION

LAST NAME____________________ FIRST NAME ____________________

DATE OF BIRTH ____________________

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

MARITAL STATUS *(Optional)*:

○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Undisclosed ○ Common-Law

ADDRESS *(No., Street)* ____________________

CITY ____________________ COUNTY ____________________ STATE __________

ZIP CODE __________ PHONE NUMBER ____________________ No Fixed Address/Undisclosed

HOUSING TYPE *(Optional)*:

○ Emergency Shelter/Mission/Transitional ○ Evacuee ○ Unhoused ○ Own Home ○ Private Rental
○ Public (Social) housing ○ With Family/Friends ○ Youth Home/Shelter ○ Undisclosed ○ Other

LANGUAGE *(Optional)*: ____________________

ETHNICITY: *(Ethnicity is REQUIRED for CSFP)* ☐ White/Anglo ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Asian ☐ N/A ☐ American Indian/Native American ☐ Alaska Native/Aleut/Eskimo ☐ Middle Eastern/North African ☐ Other ☐ Undisclosed

SELF-IDENTIFIED AS *(Optional)*: ☐ Disabiltiy ☐ Undisclosed ☐ Veteran ☐ Mental Illness ☐ N/A ☐ Pregnant ☐ Postpartum ☐ Breastfeeding ☐ Other

AUTHORIZATION FOR PROXY

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

PROXY'S PRINTED NAME(S):

____________________ ____________________ ____________________

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.CSFP Clients: I am 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.

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**

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

APPLICANT'S NAME *(Please Print)* ____________________

APPLICANT'S SIGNATURE ____________________ DATE __________

See reverse for statements and form review.

HOUSEHOLD MEMBER INFORMATION 1

LAST NAME ______________________ FIRST NAME ______________________

DATE OF BIRTH ______________________

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

HOUSEHOLD MEMBER INFORMATION 2

LAST NAME ______________________ FIRST NAME ______________________

DATE OF BIRTH ______________________

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

HOUSEHOLD MEMBER INFORMATION 3

LAST NAME ______________________ FIRST NAME ______________________

DATE OF BIRTH ______________________

RELATIONSHIP

○ Spouse ○ Child ○ Parent ○ Sibling ○ Grandparent ○ Other Relative ○ Boyfriend/Girlfriend
○ Friend ○ Undisclosed

GENDER *(Optional)*:

○ Male ○ Female ○ Transgender ○ Undisclosed ○ Other

APPLICANT IS RECEIVING THE FOLLOWING

○ Supplemental Nutrition Assistacned Program (SNAP)

○ Commodity Supplemental Food Program (CSFP)

○ Other *(Specify)*:

See page 3 for USDA nondiscrimination and EOE/ADA/LEP/GINA, statements and form review.