

1720 Wyoming St.
Missoula, MT 59801



Dear Potential ROOTS Recipient:

Thank you for your interest in receiving food from Missoula Food Bank through our ROOTS-senior grocery delivery program. Missoula Food Bank and the Department of Health and Human Services partner to deliver a free, nutritious monthly food package to seniors living on a low income.

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 we 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 (406) 549-0543 and ask for Jess Harrell ext.216.

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.

2021 Income Guidelines

FFY 2021 Initial Exhibit B						
2021 Commodity Supplemental Food Program (CSFP)						
ELDERLY INCOME GUIDELINES						
130% OF POVERTY LEVEL OR LESS						
Guidelines Effective March 12, 2021						
130% OF POVERTY INDEX						
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130% OF POVERTY INDEX						
HOUSEHOLD SIZE	FEDERAL POVERTY 2019 GUIDELINES ANNUAL	CSFP ELDERLY ELIGIBILITY GUIDELINE - 130% OF POVERTY				
		ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	\$12,880	\$16,744	\$1,396	\$698	\$644	\$322
2	\$17,420	\$22,646	\$1,888	\$944	\$871	\$436
3	\$21,960	\$28,548	\$2,379	\$1,190	\$1,098	\$549
4	\$26,500	\$34,450	\$2,871	\$1,436	\$1,325	\$663
5	\$31,040	\$40,352	\$3,363	\$1,682	\$1,552	\$776
6	\$35,580	\$46,254	\$3,855	\$1,928	\$1,779	\$890
7	\$40,120	\$52,156	\$4,347	\$2,174	\$2,006	\$1,003
8	\$44,660	\$58,058	\$4,839	\$2,420	\$2,233	\$1,117
For each add'l family member, add.....	\$4,540	\$5,902	\$492	\$246	\$227	\$114

Based on the US Department of Health and Human Services Annual Update of the Poverty Guidelines as published in the Federal Register #86 FR 7732, pages 7732-7734, Document #2021-01969

DATE: _____

ELDERLY COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP) APPLICATION

Applicant: _____
Last Name First Name Middle Initial

Mailing Address: _____
Number Street Apartment /Unit #

_____ City Zip County

Physical Address: _____
Number Street Apartment /Unit #

_____ City Zip County

Phone: _____ Email: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Ethnic Data Collection Requirement:

Hispanic or Latino or Not Hispanic or Latino

Racial Data Collection Requirement: (select one or more)

American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or other Pacific Islander White _____

Please Choose:

I would like to pick my food up at Missoula Food Bank monthly: _____

I would like my food to be delivered to my home monthly: _____

Do you currently receive SNAP benefits (formerly known as food stamps)? _____

Are you a veteran? _____

Number of People in Household Including Applicant: _____

<u>Household Members:</u>	<u>Age:</u>	<u>Date of Birth:</u>	<u>Relationship:</u>

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

SOURCE OF INCOME	AMOUNT RECEIVED	HOW OFTEN RECEIVED (i.e. weekly, monthly, yearly)
Wages, Salary		
Social Security		
Supplemental Security Income (SSI)		
Public Assistance (TANF)		
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.

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 individuals are authorized to act as my representative for CSFP:		
_____ Name	_____ Relationship	_____ Phone
_____ Name	_____ Relationship	_____ Phone

FOOD CHOICES

(Subject to availability)

1. CHOOSE ONE:

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

2. CHOOSE ONE:

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

3. CHOOSE ONE:

- Chicken (1 can) **or**
- Tuna (1 can) **healthy choice**

4. CHOOSE ONE:

- Peanut Butter (1 jar) & Beans (2 cans)
- Beans (3 cans) **healthy choice**

5. CHOOSE ONE:

- Spaghetti (2 lbs) **or**
- Macaroni (2 lbs) **or**
- Rice (2 lbs) **healthy choice**

Everyone will receive:

3 bottles of Ensure Protein Drink, Juice, 2 lbs of Cheese, Liquid Milk, 1 box of Raisins, 1 can of Fruit, 8 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.

IF INELEGIBLE PLEASE STATE REASON: _____

CERTIFICATION ID VERIFIED: _____ INCOME VERIFIED _____

ELIGIBLE _____ NOT ELIGIBLE _____

CERTIFICATION DATE FROM _____ TO _____

TITLE OF CERTIFIER _____ SIGNATURE _____
DATE _____

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.