PRAIRIE BAND POTAWATOMI NATION

Food Distribution Program * 15189 K Road * Mayetta, KS 66509

Office Phone 785-966-2718 * Warehouse Phone 785-966-2150 * Fax 785-966-2529

Email pbpn.fdp@gmail.com

INSTRUCTIONS: Complete the following information. If you refuse to cooperate, or provide verification, your application will be denied. YOU MUST PROVIDE PROOF OF ALL INCOME AND ALLOWABLE DEDUCTIONS FOR ALL HOUSEHOLD MEMBERS LISTED.

Applicant's Name: _____ Phone Number: _____

Home Address (Street Address): _____ City/State/Zip: _____

Mailing Address (if different from above): _____

In which county do you reside? (Circle one): Jackson Brown Other Is your residence on the Reservation? **YES** **NO**

If you do NOT live on the Reservation, your household must contain AT LEAST ONE PERSON who is a member of a Federally-recognized Indian Tribe. (PLEASE PROVIDE PROOF OF TRIBAL MEMBERSHIP.)

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.

	NAMES OF ALL HOUSEHOLD MEMBERS (Last, First, Middle Initial)	RELATIONSHIP TO APPLICANT (self, spouse, son, daughter, cousin, etc.)	SSN	DOB
1		**SELF**		
2				
3				
4				
5				
6				
7				
8				

Are you or anyone in your household currently receiving *SNAP benefits? **YES** **NO** If yes, list name(s): _____
***Supplemental Nutrition Assistance Program (SNAP) was formerly known as "food stamps".**

Have you or anyone in your household recently applied for SNAP benefits? **YES** **NO** If yes, list name(s): _____

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 listed above, including: Wages, Social Security, SSI, TANF, general/public assistance, foster care payments, unemployment or workers' compensation, child support, alimony, pensions, veteran's benefits, work/training allowances, etc. Verification of income is required for ALL household members listed above (pay check stubs, benefit letters, etc.). Households with earned income must provide a FULL MONTH'S wage statements. **BANK STATEMENTS DO NOT QUALIFY AS VERIFICATION OF INCOME.**

HOUSEHOLD MEMBER	EMPLOYER / OR SOURCE OF INCOME	TYPE OF INCOME	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, Schedule F, C, E, or other proof of self-employment costs and income such as current books showing income and expenses.

HOUSEHOLD MEMBER	TYPE OF BUSINESS farm, ranch, rental, daycare, etc.	OCCUPATION	HOW OFTEN PAID Monthly, Bi-weekly, Weekly

IT IS THE HOUSEHOLD'S RESPONSIBILITY TO PROVIDE DOCUMENTATION FOR ALLOWABLE DEDUCTIONS.

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 of person providing care) _____

Address: _____ Phone Number: _____

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 this month: $_____

MEDICARE: Does anyone in your household pay Medicare Part B Medical Insurance &/or Part D Prescription Drug Coverage Premium? **YES** **NO** If yes, list household member: _____ Amount Paid: $_____

EXCESS MEDICAL EXPENSES: Does anyone in your household, who is age 60 or older, or disabled, pay more than $35/month for Medical Expenses? **YES** **NO** If yes, list household member: _____ Amount Paid: $_____

TYPE OF MEDICAL EXPENSE (PLEASE EXPLAIN):

STANDARD SHELTER/UTILITY EXPENSE: Does anyone in your household pay, on a monthly basis, at least one shelter or utility expense? **YES** **NO** If yes, list household member: _____ Amount Paid Monthly: $_____

TYPE OF SHELTER OR UTILITY EXPENSE (PLEASE EXPLAIN):

HOME CARE MEAL-RELATED DEDUCTION: Do you furnish the majority of meals for a home care attendant? **YES** **NO**

AUTHORIZED REPRESENTATIVE(S): To authorize someone outside your household to pick up your food, complete this section.

NAME	ADDRESS	PHONE NUMBER

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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? (Please circle one.) Hispanic or Latino **---OR---** Not Hispanic or Latino

2. What is your race? (Please circle all that apply to you.) Native American or Alaskan Native Asian Black/African American
Native Hawaiian or Pacific Islander White

3. What is your Tribal Affiliation? _____

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. If you request a fair hearing, your case may be presented by a household member or representative, such as legal counsel, a relative, a friend or other spokesperson.

PENALTY WARNINGS: If your household receives USDA commodity food, 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 that your household is not entitled to receive.**
2. **Do not misuse (e.g., trade or sell) USDA commodity food.**
3. **Do not participate simultaneously in the Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program.**
4. **Do not commit any act that violates a Federal statute or regulation relating to the acquisition or use of USDA Food Distribution Program commodities.**

INTENTINAL PROGRAM VIOLATION (IPV) PENALTIES: If you or any member of your household knowingly and willingly 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. Individuals committing an IPV may be referred to authorities for prosecution.

AUTHORIZATION: I authorize the release of any necessary information or forms to the Potawatomi Food Distribution Program from individuals, businesses, employers, schools, banking institutions, Federal, State, or Tribal agencies needed to determine and verify my eligibility. I understand that this information will be used only for the purpose of helping to document my eligibility for FDPIR benefits. This authorization is valid for the time designated on this application from the date signed or until revoked by me in writing. This time frame will not exceed twelve (12) months.

CERTIFICATION STATEMENT: I certify that I have read this application and that the information contained herein is true and accurate 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 any changes in household size or composition; an increase in gross monthly income of more than $100; a change in residence/address; when the household no longer incurs a shelter/utility expense; or a change in the legal obligation to pay child support to the Potawatomi Food Distribution Program **within ten (10) calendar days** of the date the change becomes known.

APPLICANT'S NAME (Please Print Legibly): _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

RECEIVED BY: _____ **DATE RECEIVED:** _____

USDA Nondiscrimination Statement

SNAP and FDPIR State or local agencies, and their subrecipients, must post the following Nondiscrimination 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, 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: 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.

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