ADDENDUM TO THE PENNSYLVANIA STATE
COMMODITY SUPPLEMENTAL FOOD PROGRAM
PLAN OF OPERATION

September 1, 2020

Section 1.06 Certification Criteria and Procedures/Certification Form currently reads as follows: *CSFP applicants will be required to complete a CSFP Certification Form (see Attachment "B".*

Attachment B is a copy of the CSFP Certification Form. Included on this form are the following certification statements that the applicant must agree to by signing the form.

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 also aware that I may not receive both CSFP and WIC benefits simultaneously, and I may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, 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 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***

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 dministering 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.

Section 1.17 Distribution Methods and Frequency currently reads as follows: *The participant of authorized proxy will sign certification and/or CSFP food issuance documents, and then pick up the CSFP food package.*

An example of this sign in form is included at the end of this addendum.

Effective March 11, 2020 through March 31, 2021 out of an abundance of caution due to concerns over the spread of COVID-19, this plan will be temporarily modified to waive the signature requirement. Instead, during this period of time, CSFP Lead Agencies and CSFP Sub Agencies will adhere to the following procedure.

1. *Read the following authorization to the participant, proxy or caretaker: "Do you agree to give me (insert staff/volunteer name) permission to sign your CSFP Monthly Signature Form [#102043] or CSFP Certification Form [#202002] on your behalf? Please indicate yes or no."*

2. ***For Form 202022 Certification Form*** *If the participant authorizes the staff/volunteer to sign, the staff/volunteer should read the following statements provided on the form to the participant and ensure that the participant is aware that if they allow the staff/volunteer to sign on their behalf, they (the participant) are attesting or certifying to the truth of the information provided.*

   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 may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, 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.

   The staff/volunteer will sign their own name on the signature line of Form 202022, then write: "Signature Authorized by (participant/proxy/caretaker name) (via phone or in-person) on (date/time)."

3. ***For Form 102043 Monthly Signature Form*** *one new/ one amended column will be as follows: New - "Signature Authorized by participant/proxy/caretaker- circle yes or no"; Amended - "Time" will be added to the current Date column.*

Commonwealth of Pennsylvania
Department of Agriculture
Bureau of Food Assistance

Caryn Long Earl

Caryn Long Earl, Bureau Director

September 1, 2020
Date

CSFP Participant Certification Form 202002

pennsylvania DEPARTMENT OF AGRICULTURE BUREAU OF FOOD DISTRIBUTION | CSFP | HUNGER-FREE PENNSYLVANIA A Network of Food Banks & Charitable Organizations

Name of Participant:	**Date of Birth**:_____ [Participant Must Provide Proof]	◯**Male** ◯**Female**
Street Address: **Apt:**	**City**:	**Zip**:
Home Phone Number:	**Cell Phone Number**:	

Total Household Income Amount $ _____ **How many persons live in this household**? _____ (if more than 1, see below)

Household Income Reported is Received [Check One]: ◯Weekly ◯Monthly ◯Annually

Source of Income: ◯Disability ◯Pension ◯Social Security ◯Underemployment ◯Unemployment

Form of ID Provided? ◯Driver's License ◯Birth Certificate ◯Passport ◯PA ID Card ◯Resident Alien Card

Are you Hispanic or Latino? [Check Only One] ◯Yes ◯No

What is your race? [Check All That Apply] ◯American Indian or Alaska Native ◯Asian ◯White ◯Black or African American ◯Native Hawaiian or Another Pacific Islander

ADDITIONAL HOUSEHOLD MEMBERS MUST BE LISTED BELOW:

Household Member	First Name	Last Name	Birthdate	Gender [Circle One]
1				Male or Female
2				Male or Female
3				Male or Female
4				Male or Female

For additional household members turn over.

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I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining 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 Participant / Caretaker [Circle One]:

Caretaker Only - Print Name:

Proxy 1 – Print Name: **Proxy 1 Signature**: **Date**:

Proxy 2 – Print Name: **Proxy 2 Signature**: **Date**:

Site Name:	**County**:
Site Representative Signature:	**Date**:

Household Member	First Name	Last Name	Birthdate	Gender Circle One
5				Male or Female
6				Male or Female
7				Male or Female
8				Male or Female

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pennsylvania
DEPARTMENT OF AGRICULTURE
BUREAU OF FOOD ASSISTANCE

Commodity Supplemental Food Program

Insert Sub-Agency Name

Insert Month & Year

SHEET DUE DATE: ***3-days after distribution***

Form 102043 Sub-Agency Monthly Participant Sign-In Sheet

Participant [Caretaker]			Proxy Last Name IF APL	Signature [Person picking up food package]	Date
Count	Last [Caretaker]	First [Caretaker]			
1					
2					
3					
4					
5					