YUROK TRIBE CLIENT SERVICES DEPARTMENT

190 Klamath Boulevard • Post Office Box 1027 • Klamath, CA 95548

Phone: 855-55-YUROK

Yurok Food Distribution Program

Food Dist. Email: *fdp@yuroktribe.nsn.us*

Answer the following questions honestly and completely. If you know but refuse on purpose to give any needed information, your household (you and the people who live and eat with you) will not be eligible for food distribution. You may complete this form at home and/or bring it back to the office. You may also mail, email, or fax in your application.

IMPORTANT: When you are interviewed, please bring proof of all household income for the entire month.

For example: Check stubs and award letters for government benefits (such as Social Security, VA, or SSI). **We will no longer be accepting bank statements.**

❖ APPLICATION CHECK LIST FOR NEW CLIENT

- ☐ **Verification of last 30 days of income/Zero income form for head of household**
- ☐ **Verification of physical address Utility Bill, Rental Agreement, Phone Bill, or Certification of Living Arrangements**
- ☐ **Tribal Verification**
- ☐ **Photo ID for ALL ADULTS in household**
- ☐ **Supporting documents if using ANY deductions**

❖ RECERTIFICATIONS:

- ☐ **Verification of last 30 days of Income/Zero Income form for Head of Household**
- ☐ **Utility Bill, Rent Receipt, Phone bill or Certification of living arrangements for Verification of Residence, for physical address**
- ☐ **Verification of any Dependent/Childcare costs**

❖ TO ADD TO YOUR HOUSEHOLD:

- ☐ **Applications must be received one month prior to receiving benefits. For example: If the application is received in March, then the new household member(s) will be added to your household in April.**
- ☐ **Verification of Income for new member(s) (if receiving)**
- ☐ **Photo Identification if the new member is an adult.**

Having these items with you at the time the application is turned in will help to expedite the application process.

Instructions: Complete the following information. If you **refuse to cooperate or provide verification,** your application will be denied. You must provide proof/verification of all income and allowable deductions.

Name (Head of Household): _____ County: _____
Mailing Address: _____ Household Size: _____
Street Address: _____ Phone No.: _____
City/State/Zip: _____
Directions to Your Home: _____

HOUSEHOLD MEMBERS: Complete the following for each member of your household. Your household means yourself and the people who live/eat with you. Do not include boarders. List your name first. (Attach a separate sheet if you need to list additional household members.)

Name(s) of all Household Members (Last, First, Middle Initial) **Please Print**	**Relationship to Head of Household**	**Date of Birth**	**Social Security #**
1.	**SELF**		
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you or anyone in your household currently receiving SNAP (Food Stamps) benefits?
☐**Yes** ■ **No** If yes, list names: _____

Have you or anyone in your household recently applied for SNAP (Food Stamp) benefits?
☐**Yes** ☐ **No** If yes, list names, date applied and outcome:

_____

Have you or anyone in your Household been disqualified from SNAP for an Intentional program violation?
☐**Yes** ☐ **No** If yes, list names: _____

OFFICE USE ONLY:
Called county office of _____ on ___/___/___ and spoke to _____

SNAP/SSI Verified by: _____

INCOME: List income from all sources for each Household member including wages, social security, SSI, TANF, general/public assistance, foster care payments, unemployment or worker's compensation, child support, alimony, pensions, Veteran's benefits, per capita payments from gambling enterprises, work/training allowances, etc. Verification is required for all household members who receive income (Check stubs, SSI award letters, ETC.) Households are required to provide the past 30 days of income. Attach a separate sheet if you need to list additional household members.

HOUSEHOLD MEMBER	EMPLOYER/ SOURCE OF INCOME	TYPE OF INCOME (Wages, social security, TANF, child support, etc.)	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.

Payments from rental property, roomers, boarders, farming, ranching, and/or operating your own business are considered to be self-employment. Please provide a copy of last year's Federal Income Tax form (1040, Schedules F, C, E, if applicable, or other proof of self-employment costs and income (current books showing income and expenses).

HOUSEHOLD MEMBER	TYPE OF BUSINESS (Farm, ranch, Rental, Day Care, ETC.)	OCCUPATION	Is this your primary source of Income for meeting your living expenses?

STUDENTS: Are there any students in your Household who receive education grants, scholarships or loans?

□ YES □ NO

If Yes, please complete the following section. Please provide verification.

HOUSEHOLD MEMBER	AMOUNT OF LOAN/GRANT	PERIOD OF TIME FUNDS INTENDED TO COVER	TYPE OF PAYMENT (Pell Grant, Student Loan, BIA)	Amount used to pay Tuition/School Fees/Other related expenses.

ALLOWABLE DEDUCTION (Please provide verification):

STANDARD SHELTER/UTILITY EXPENSE: Does anyone in your household pay monthly, at least one shelter/utility expense?

☐**Yes** ☐ **No** If yes, type of Shelter/Utility expense paid monthly: _____

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 an education which is preparatory to employment?

☐**Yes** ☐ **No** If yes: Name and address of person providing care: _____

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: $_____ How often_____

EXCESS MEDICAL EXPENSES: Anyone in your household elderly and/or disabled?

☐**Yes** ☐**No** If yes, complete the following:

Monthly total medical expenses:_____. (Milage for medical, prescriptions, medical insurance, payments for medical devices, etc. Do not include expenses from special diets.)

AUTHORIZED REPRESENTATIVE: To authorize someone outside of your household to act on your behalf with paperwork and/or pick up your food, complete this section.				
NAME(S)	**PHONE NUMER**	**Pick Up**	**Paperwork**	**Both**

RACIAL/ETHNIC DATA:

What is your ethnic category? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your race? ☐ American Indian or Alaskan Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian or Pacific Islander

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 WARNING: If your household receives USDA food benefits, 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, household size, and/or participation in the Supplemental Nutrition Assistance Program (SNAP) in order to obtain Food Distribution benefits which your household is not entitled to receive.**
2. **Do not misuse (trade, sell, ETC.) USDA foods**
3. **Do not participate simultaneously in the Supplemental Nutrition Assistance Program (SNAP) and the Food Distribution Program.**
4. **INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES:** If you or any member of your household knowingly and willingly violates the rules above it is considered and Intentional Program
5. 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. Individual(s) committing an IPV may be referred to authorities for prosecution.

AUTHORIZATION TO RELEASE INFORMATION: All adult household members must sign. I authorize the release of any necessary information or forms to the Food Distribution Office from individuals, businesses, schools, banking institutions, Federal/State/Tribal agencies needed to determine/verify my eligibility. I understand that this information will be used only for the purpose of helping to document my eligibility for Food Distribution benefits. This authorization is good for 12 months from the date signed or until revoked by me in writing.

Printed Name	Date of Birth	Signature	Date Signed

CERTIFICATION STATEMENT: I certify that I have read this application and that the information contained in it is true and correct 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 within **10 calendar days** after the change becomes known the following changes: a change in household size or composition; an increase in monthly income of more than $100; a change in residence/address; when the household no longer incurs a shelter or utility expense; or a change in the legal obligation to pay child support.

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002- 508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD- 3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service,
   USDA 1320 Braddock Place,
   Room 334 Alexandria, VA
   22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.