Office Use Only = CSFP ID: _____

Commodity Supplemental Food Program 2026 Application

Mail completed application to: Food Bank of Wyoming
P.O. Box 1540
Evansville, WY 82636
Or Email copy to: HelpDesk@WyomingFoodBank.org

Wyoming individuals are eligible to receive monthly CSFP commodity boxes, if the total gross income for the household does not exceed 130% of the federal poverty level and the individual applying is at least 60 years of age. Eligibility is based on self-declared income.

NAME OF APPLICANT:	**TELEPHONE NUMBER:**	**COUNTY:**
PHYSICAL ADDRESS (Street, City, Zip Code)**:**	**MAILING ADDRESS** *(if different)* (Street, City, Zip Code)**:**	
APPLICANT'S DATE OF BIRTH:	**TOTAL INDIVIDUALS IN HOUSEHOLD:**	
OTHER HOUSEHOLD MEMBERS	**DATE OF BIRTH**	

Indicate the amount of current (last month's) income before any deductions, such as taxes and social security**. This amount must include the income of all household members.** If last month's income is not representative of usual household income, also indicate household's average income during the previous 12 months.	**CHANGES MUST BE REPORTED:** Participants must report changes in household income or composition **within 10 days** after the change becomes known to the household

TOTAL MONTHLY GROSS HOUSEHOLD INCOME: _____
*(Please write in the **total gross income** for the entire household on the line)*

February 2025 - January 2026 Eligibility Guidelines

Household Size	Maximum Gross Monthly Income	Maximum Gross Annual Income
1	$1,729	$ 20,748
2	$ 2,345	$ 28,132
3	$ 2,960	$ 35,516
4	$ 3,575	$ 42,900
5	$ 4,191	$ 50,284
6	$ 4,806	$ 57,668
7	$ 5,421	$ 65,052
8	$ 6,037	$ 72,436
Each Additional Member	+ $ 616	+ $ 7,384

Racial and Ethnic Data – For Statistical Purposes Only

What do you identify as racially/ethnically?
Select all that apply.

- ☐ Alaskan Native/Aleut/ Eskimo
- ☐ American Indian/ Native American
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/ Latino
- ☐ Middle-Eastern/North African
- ☐ Pacific Islander
- ☐ White/ Anglo/ Caucasian

This institution is an equal opportunity provider.

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BEFORE SIGNING, BE AWARE OF YOUR RIGHTS AND WHAT YOUR SIGNATURE MEANS:

- ✓ Standards for participation in the Program are the same for everyone regardless of race, color, national origin, sex, age and disability.
- ✓ You may appeal any decision made by the local agency regarding your denial or termination from the Program.
- ✓ You will be given nutrition, health and social services referral information and are encouraged to seek needed assistance.
- ✓ If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate.

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 CSFP benefits at more than one CSFP site at the same time; and improper use or receipt of CSFP benefits as a result of dual participation or other program violations may lead to a claim against me to recover the value of the benefits and may lead to disqualification from CSFP. 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 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**
SIGNATURE OF PROXY	**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), disability, age, 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 responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, 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 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

* **FOR CERTIFYING AGENCY USE ONLY** * * * * * * * * * * * * * * * * * * *			
The following have been verified: ☐ Identity ☐ Residency ☐ Age ☐ Household Members	**APPLICANT ELIGIBLE?** ☐ Y ☐ N	**CASELOAD AVAILABLE?** ☐ Y ☐ N	**DATE WRITTEN NOTICE GIVEN:**
☐ **NEW APPLICATION** ☐ **RECERTIFICATION**			
CERTIFYING OFFICIAL SIGNATURE	**DATE CERTIFIED**	**PERIOD OF CERTIFICATION** **1st Mo:** **Last Mo:**	