Arizona Department of Economic Security
Child and Community Services Division - Coordinated Hunger Relief Program

Application for Benefits

◯ TEFAP ◯ CSFP

Applicant Information

Last Name: _____ First Name: _____

Date of Birth: _____ Number of People in the Household: _____

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Marital Status *(Optional)*: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Undisclosed ☐ Common-Law

Address *(No., Street)*: _____

City: _____ County: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Housing Type *(Optional)*: ☐ Housed ☐ Homeless ☐ With family or friends ☐ Other ☐ Prefer not to answer

Language *(Optional)*: _____

Ethnicity *(Required for CSFP)*: ☐ White/Anglo ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Asian ☐ American Indian/Native American ☐ Alaska Native/Aleut/Eskimo ☐ Middle Eastern/North African ☐ Other

Self-identified as *(Optional)*: ☐ Disability ☐ Undisclosed ☐ Veteran ☐ Mental Illness ☐ N/A ☐ Pregnant ☐ Postpartum ☐ Breastfeeding ☐ Other

Authorization for Proxy

I understand that I must pick up my food regularly and that I may be terminated from CSFP if I fail to pick up my food. In the event that I am unable to pick up my food, please release it to:

Proxy's Printed Name(s):

_____ _____ _____

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. CSFP Clients: 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

See page 3 for USDA/EOE/ADA disclosures

I certify that my gross household income is equal to or below the federal poverty level acceptable for the program I am applying for. I have reviewed the current income eligibility chart and received an explanation of countable and non-countable income.

Applicant's Name (Please Print): _____

Applicant's Signature: _____ Date: _____

Household Member Information 1

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Grandchild
☐ Other Relative ☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Household Member Information 2

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Grandchild
☐ Other Relative ☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Household Member Information 3

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Grandchild
☐ Other Relative ☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Household Member Information 4

Last Name: _____ First Name: _____

Date of Birth: _____

Relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Grandparent ☐ Grandchild
☐ Other Relative ☐ Boyfriend/Girlfriend ☐ Friend ☐ Undisclosed

Gender *(Optional)*: ☐ Male ☐ Female ☐ Undisclosed

Please send this completed application to

Email: coordinatedhungerreliefprogram@azdes.gov

Mail: Arizona Department of Economic Security
Child and Community Services Division
Coordinated Hunger Relief Program (Mail Drop 4382)
1789 W. Jefferson Street
Phoenix, AZ 85007

For more information about DES food assistance programs, please visit:

des.az.gov/services/basic-needs/food-assistance

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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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** program.intake@usda.gov.

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