

Tribal Members, Birth, SScard. Income + Residence

Administered
By Tolumne Band
(209) 928-5300

TULE RIVER
Food Distribution Program on Indian Reservations
Address: 2780 W. YOWLUMNE #B Porterville, CA 93257
Telephone: (559) 781-3128
Fax: (559) 781-9192

IMPORTANT: When you are interviewed, please bring proof of all household income—for example, bring any pay stubs and award letters for government benefits (such as SSI or Social Security) and proof of residence such as a utility bill, all dated within the last 30 days. We also need statements on all household savings and checking accounts and dependent care cost, copies of Social Security cards and information on all school tuition, grants, loans, etc.

Name: _____ Telephone #: _____ Tribal ID #: _____

Mailing Address: _____ City _____ State _____ Zip _____

Actual Street Address: _____ City _____ State _____ Zip _____

New: _____ Recertification: _____ Date Received: _____

HOUSEHOLD MEMBERS: Please include the Social Security number of each member of your household who has one. This will help us identify your household correctly. These Social Security numbers may also be used in program reviews or audits to make sure your household is eligible for the Food Distribution Program.

Name (First, Middle, Last)	Relation to Head of Household	Age	Birth date	Social Security No. For Each Household Member
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

RACIAL/ETHNIC DATA COLLECTION: This Information is voluntary. If you do not provide this information, it will not affect your eligibility.

- Are you Hispanic or Latino? Choose one of the following: Yes No
- What is your race? Choose any of the following that apply:
 American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

FOOD STAMPS: Have you or any household members applied for food stamps, or are receiving food stamps?
 Yes No If yes, in what county?: _____
 In which month(s) and year did you receive food stamps: _____

INCOME RECEIVED DURING PAST 30 DAYS FROM WORK: Fill in all blanks for each member with a full or part time job. If a member has more than one job, list each separately.

Household Members Name	Name of Employer	Gross Income	How Often

SELF-EMPLOYMENT INCOME: Is anyone in your household self-employed? Yes No
 If Yes, Name/Type of Business _____

STUDENTS: Is anyone in your household receiving Education Grants or Loans? Yes No
 Name: _____ Type of Grant or Loan: _____ Amount: \$ _____
 Length of Funding: _____

RESOURCES: Cash on Hand: \$ _____ Savings Account: \$ _____ Checking Account: \$ _____
 Savings Certificates: \$ _____ Stocks or Bonds: \$ _____ Other: \$ _____ TOTAL: \$ _____

DEPENDENT CARE: Does anyone in your household pay for someone to baby-sit or care for a child or a disabled adult, so that a member can work or go to school or training? Yes No
 Name of provider: _____ Amount Paid: \$ _____

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: \$ _____

MEDICARE: Does anyone in your household pay Medicare Part B Medical Insurance and/or Part D Prescription Drug Coverage? Yes No If yes, Please complete the following:
 Name: _____ Amount Paid Part B: \$ _____ Amount Paid Part D: \$ _____

CHECK ALL THAT APPLIES TO YOUR HOUSEHOLD

Type of Income	YES	NO	Name of person Who receives it	Amount Received
TANF (Temporary Assistance for Needy Families)				
SSI (Supplemental Security Income)				
GA (General Assistance) or A/D (Aid to Disabled)				
Veterans Benefits				
Social Security Income				
Pensions or Retirement Income				
Unemployment or Workers Compensation				
Child Support or Alimony				
Money from Friends or Relatives (other than a loan)				
Gas or Oil Royalties or other per capita payment				

AUTHORIZED REPRESENTATIVE: You may authorize someone outside your household to pick up your food package. Please list them below:

Name: _____ Address: _____ Telephone # _____
 Name: _____ Address: _____ Telephone # _____

FAIR HEARING: If you disagree with any action taken on your case, you and 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 member of your household or representative, such as a legal counsel, a relative, a friend or other spokesperson.

PENALTY WARNING: If your household receives commodity food, it must follow the rules listed below:

- > Do not give false information or hide information in order to get, or continue getting commodity food.
- > Do not trade or sell commodity food
- > Do not participate in the Food Stamp Program and the Food Distribution Program at the same time.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: If you or a household member 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, 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: 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 verify my eligibility for the Food Distribution Program. I understand that this information will be used only for the purpose of helping to document my eligibility for the Food Distribution Program and will be kept confidential. This authorization is good for 12 months from the date signed or until revoked by me in writing.

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 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 the household size, income and/or resources to the Food Distribution Program Office within 10 days of the date the change becomes known.

Applicant's Signature _____ Date: _____

Caseworker's Signature _____ Date: _____

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