

FOOD DISTRIBUTION PROGRAM APPLICATION

P.O. Box 908
Lawton, OK 73501
(580) 492-3325 or 492-3328

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

Name (Head of Household): _____

Telephone Number (include area _____) Household Size: _____

Home Address (Street, P.O. Box): _____

City, State, Zip Code, _____

Mailing Address (if different from above): _____

Directions To Your Home: _____

HOUSEHOLD MEMBERS: Complete the following for each member of your household. Your household means yourself and the people who live with you. 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 (self, spouse, daughter, son, cousin etc.)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Are you or anyone in your household currently receiving food stamps? Yes No
If yes, list names: _____

Have you or anyone in your household recently applied for Food Stamps? Yes No
If yes, list names: _____

Have you or anyone in your household been disqualified from the Food Stamp Program for an intentional program violation?
 Yes No. If yes, list name(s): _____

INCOME (EARNED & UNEARNED): 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 of income is required for all household members (pay check stubs, award letters, etc.). Households with earned income must provide a full month's wage statements. 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. Payment from rental property, roomers, boarders, farming, ranching, and/or operating your own business is 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 your self-employment the 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, 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

RESOURCES: List resources for all household members, except roomers and boarders. (Attach additional names on a separate sheet).

HOUSEHOLD MEMBER	CASH ON HAND	CHECKING/SAVINGS ACCOUNT	STOCKS, BONDS, CERTIFICATES OF DEPOSIT, OTHER

ALLOWABLE DEDUCTIONS [Please provide verification]:

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 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 Paid: \$ _____ Amount ordered to pay: \$ _____ Amount actually paid: \$ _____

MEDICARE: Does anyone in your household pay Medicare Part B Medical Insurance? Yes No

IF YES: Complete the following: Household Member: _____ Amount Paid: \$ _____

AUTHORIZED REPRESENTATIVE: To authorize someone outside your household to pick up your food, complete this section.

NAME(S)	ADDRESS	TELEPHONE NUMBER

RACIAL/ETHNIC HERITAGE: This information is voluntary. If you do not provide this information, it will not affect your eligibility.
 American Indian or Alaskan Native White Black Asian or Pacific Islander Hispanic Origin

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 a legal counsel, a relative, a friend or other spokesperson.

PENALTY WARNING: If your household receives commodity food 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, resources, household size, and/or participation in the Food Stamp Program in order to obtain Food Distribution Program benefits which your household is not entitled to receive.
2. Do not trade or sell commodity food.
3. Do not participate simultaneously in the Food Stamp Program and Food Distribution Program.
4. Do not commit any act that violates a Federal statute or regulation relating to the acquisition or use of Food Distribution Program commodities.

If you or any member of your household 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, 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: 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.

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 any changes in household size, income and/or resources to the Food Distribution Office within ten days of the date the change becomes known.

Applicant's Signature _____ Date _____

*In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication and Compliance, 1400 Independence Avenue, SW, Washington, DC 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY)."

COMANCHE NATION
FOOD DISTRIBUTION PROGRAM
584 NW BINGO ROAD
LAWTON, OK 73502
OFFICE: 580 492-3328
492-3325
FAX: 492-3744

Application Check List

The following documents are needed to complete your application.

PLEASE BRING COPIES

- _____ Social Security Card(s) for all household members
- _____ Verification of Residency (Lease or Utility bill)
- _____ Certification of Indian Blood (CDIB) or Enrollment Letter
- _____ Verification of Fixed Income (such as Social Security, SSI, VA Pension, Annuity, AFDC, GA, TWEPE Grant, Child Support, Alimony, Foster Care Payments)
- _____ Verification of Employment (for all household members over 18 years of age) full months paystub(s)
- _____ Verification of Unemployment or Written Statements from a friend or relative
- _____ Verification of Businesses/Self Employment (monthly ledger)
- _____ Verification of Schooling (grant papers that are awarded, and Financial Statements)

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To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.