DPHHS-FD-001
(Rev. 4/06)

STATE OF MONTANA
Department of Public Health and Human Services

FOOD DISTRIBUTION APPLICATION

OFFICE USE ONLY
Case No.:
I.D. No.:
Expiration Date:
County: Loc:
No. in Household:

APPLICANT: COMPLETE THIS SECTION

NAME (Head of Household)	
ADDRESS	
CITY, STATE, ZIP CODE	DATE OF BIRTH
PHONE NO.	SOCIAL SECURITY NO.

Racial Ethnic Heritage: Although you are not required to provide this information, your cooperation would be appreciated. If you decline to provide this information, it will in no way effect consideration of your application. Enter appropriate number of household members in each category.

Black (Non-Hispanic) B ___ White (Non-Hispanic) W ___
Hispanic H ___ Asian (or Pacific Islander) A ___
American Indian/Alaskan Native I ___

APPLICANT: COMPLETE THIS SECTION

Is any member of this household currently certified to receive food stamps? ☐ Yes ☐ No
Is any member disqualified from the Food Stamp Program because of fraud, or disqualified rom FDPIR? ☐ Yes ☐ No
Has this household received any income in the present month? ☐ Yes ☐ No
Does this household reside within the Food Distribution Service Area? ☐ Yes ☐ No
How many members of this household receive an AFDC or SSI grant? _____

List all resources belonging to the household:

Cash on hand _____
Savings _____
Checking _____
Stocks & Bonds _____
Bonds _____
Other _____
TOTAL _____

List household members below	List Social Security Nos. for each household member	Date of Birth	Status Code	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	
5.	5.	5.	5.	
6.	6.	6.	6.	
7.	7.	7.	7.	
8.	8.	8.	8.	
9.	9.	9.	9.	
10.	10.	10.	10.	
11.	11.	11.	11.	
12.	12.	12.	12.	
13.	13.	13.	13.	

Status Codes
M - Moved
D - Deceased
I - Ineligible
F - Food Stamp
X - Delete

Are there any individuals living with this household who provide payment to the household for lodging but not for meals?
☐ Yes ☐ No If yes, give names: _____
Do all of the individuals listed above purchase and prepare their meals together? ☐ Yes ☐ No

OFFICE USE ONLY

If the household is not certified for food stamps in the present month and lives within the Food Distribution Service Area, they are automatically eligible if 1 or 2 and 3 below applies.

1. Household has no income nor anticipates any for the current month.
2. All household member received an AFDC or SSI grant.
3. Household is within the resource limits.

If 1 and 3 above applies or if the household is likely eligible and would otherwise suffer hardship, the household may receive expedited services at the discretion of the local agency. Identity and address must be verified prior to any distribution of commodities.

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PENALTIES FOR FRAUD: The State and Federal laws provide penalties, including a fine, imprisonment, or both, for persons found guilty of obtaining donated foods for which they are not eligible by making false statements or

FAILING TO REPORT PROMPTLY any changes in their circumstances. If evidence that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.

ANYONE WHO AIDS another person to obtain donated foods fraudulently is subject to the same penalties.

I UNDERSTAND that I have the right to a fair hearing if I am not satisfied with the action taken on my application by the Food Distribution Office.

CONFIDENTIALITY: The use of disclosure by any party of any information concerning a client in violation of any rule of confidentiality or for any purpose not directly connected with the administration of the Department's or the Council's responsibilities with respect to the Food Distribution Program is prohibited, except on written consent of the client, his parent if he is a minor, or his court-appointed guardian.

CIVIL RIGHTS: This is an equal opportunity program. If you believe you have been discriminated against because of race, color, national origin, sex, age, political beliefs, religion, or handicap, write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

APPLICANT: READ ABOVE AND COMPLETE SECTION BELOW

I hereby authorize the following individuals to act as my Authorized Representatives.

NAME _____ NAME _____

NAME _____ NAME _____

NAME _____ NAME _____

I certify that this application has been explained to me (or examined by me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the Food Distribution Office necessary information to verify any statements given in this application and give permission to obtain such verification. I will also cooperate fully with State and Federal personnel in a quality control review.

I agree to inform the Food Distribution Office promptly (Within 10 days) of changes in income, living arrangements or other information which I have given, since changes may affect eligibility to receive donated foods.

Signed: _____ Date: _____

(Signature of applicant or authorized representative)

OFFICE USE ONLY

CERTIFICATION ACTION:

Status Code Date _____

Status Code _____

Status Codes
M Moved
D Deceased
I Ineligible
F Food Stamps
X Delete

APPROVED from: _____ through _____

DENIED: (Reasons) _____

Signature: _____ Date: _____

(Certifying Clerk)

CHECK APPROPRIATE BOX(ES)	Approved for expedited services ☐ Yes ☐ No	Attachment Part II - ☐ Yes ☐ No Attachment Part III - ☐ Yes ☐ No

DPHHS-FD-001A
(Rev. 4/06)

STATE OF MONTANA
Department of Public Health and Human Services

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

NAME	SOCIAL SECURITY NUMBER	CASE NO.

ADDRESS	CITY	COUNTY	ZIP

PART II - INCOME STATEMENT (Reference FNS 501 Sections 4600-4640)

Section A Earned Income (Reference FNS 501 Section 4520)

SUBSECTION A-1 CONTRACT & SELF-EMPLOYMENT INCOME (Reference FNS 501 Sections 4720-4727)

List all *gross income before taxes* from self-employment, to include payments from roomers and returns on rental property for each household member.

NAME	SOURCE	AMOUNT	HOW OFTEN RECEIVED		FOR OFFICE USE ONLY
		$			Amount to average $
					Amount to average $
					Amount to average $
					Amount to average $
					Amount to average $
A. ENTER TOTAL HERE		**$**		**D.**	**Total to average $**

List *net profits* received from the sale of capital goods or equipment within the last 12 months and enter dates of sale.

ITEM(S)	AMOUNT	DATE		FOR OFFICE USE ONLY
	$			Amount to average $
				Amount to average $
				Amount to average $
				Amount to average $
B. ENTER TOTAL HERE	**$**		**E.**	**Total to average $**

List *business expenses* and give dates expenses were incurred for the last 12 months.

EXPENSE (IDENTIFY)	AMOUNT	DATE		FOR OFFICE USE ONLY
Labor	$			Amount to average $
Stock & Raw Material (seed, fertilizer, etc.)				Amount to average $
Insurance Premiums (equipment, etc.)				Amount to average $
Property Taxes				Amount to average $
Other (Identify)				Amount to average $
				Amount to average $
				Amount to average $
				Amount to average $
C. ENTER TOTAL HERE	**$**		**F.**	**Total to average $**

FOR OFFICE USE ONLY

If income listed in Subsection A-1 is the households only means of support, the income must be averaged over a 12 month period, even if the income is received in a shorter period of time. If income in A-1 represents only a part of the households support, it should be averaged over the period of time it contributes support to the household. If the receipt of income in Sections A & B is reasonably certain, but amounts fluctuate, income may be averaged if it is to the benefit of the household.
Review A & B to determine if income is to be averaged.
If income is to be averaged, determine the number of months in the averaging period.
Calculate the amounts in Subsection A-1 that apply to the averaging period and enter these amounts in D, E & F in the same subsection.

1. If income is to be averaged, enter averaging period: From _____ to _____
2. Enter number of months in averaging period (if applicable): . . . . . Number of Months: _____
3. Add D and E in Subsection A-1 and enter the sum: . . . . . $_____
4. Enter the amount from F in Subsection A-1: . . . . . $_____
5. Subtract the amount on Line 4 from the amount on Line 3: (No less than 0) . . . . . $_____
6. Divide the amount on line 5 by number of months on Line 2: . . . . . $_____

SUBSECTION A-2 WAGES, SALARIES & OTHER INCOME FROM EMPLOYMENT

Wages, Salaries or Other Income from Employment					x	**Factors Used**	
NAME		SOURCE		AMOUNT	x		
					x		
					x		
(Use conversion factors FNS 501 Section 4621)			Total monthly wage and salary income and enter the total on this line				$

SUBSECTION A-3 TRAINING ALLOWANCES (Reference FNS 501 Section 4520C)

Training Allowances			
1. Enter monthly income received			
2. Enter monthly tuition and mandatory fees			
3. Subtract line 2 from line 1 (if amount is negative, enter 0)			$

Section B Unearned Income (Reference FNS 501 Section 4530)

SOURCE OF INCOME		
	1. SSI (Supplemental Security Income) -- Gold checks	9. Other (specify)
	2. AFDC (Aid to Families with Dependent Children)	10. Land Lease
	3. GA (General Assistance)	11. Pasture Lease
	4. Social Security -- Blue/Green checks	12. Farm Lease
	5. Pensions or retirement income	13. Oil or Gas Lease
	6. Money from friends or relatives (other than loans)	14. Other Leases (specify)
	7. Child support and alimony	15. Other Leases (specify)
	8. Unemployment or Workers' Compensation	16. Per Capita Payments (specify)

Indicate household member receiving payment and identify payment by above numbers.

NAME	NO.	AMOUNT	HOW OFTEN RECEIVED	CIRCLE CONVERSION FACTOR	MONTHLY TOTAL
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				- 1 - 2 - 2.15 - 4 - 4.3 -	
				ENTER TOTAL	**$**

Nonrecurring lump sum payments are considered a resource in the month received. Recurring payments are unearned income in the month received and a resource thereafter. Do not enter amounts included in Subsection A-1.

Section C Income Deductions

If you pay for child care or other dependent care to enable you to accept or continue work or attend training which is preparatory to employment, enter the monthly amount. Do not enter if these amounts are paid to a member of your household.

Legally Required Child Support Payments $_____

Premium for Medicare Part B $_____

TOTAL: $_____

Signature: _____ Date: _____

(Applicant or Authorized Representative)

FOR OFFICE USE ONLY

7.	Enter self-employment amount from line 6 on reverse side	7.	$
8.	Enter total monthly amount from Subsection A-2 on reverse side	8.	$
9.	Enter total monthly amount from Subsection A-3 above	9.	$
10.	Add lines 7, 8 & 9 and enter total earned income	10.	$
11.	Enter 20% of line 10. (Earned income standard deduction)	11.	$
12.	Subtract amount on line 11 from amount on line 10. (Net earned income)	12.	$
13.	Enter total monthly unearned income from Section B above	13.	$
14.	Add amounts from lines 12 and 13. (Total earned and unearned)	14.	$
15.	Enter total from Section C, Income Deductions	15.	$
16.	Subtract amount on line 15 from amount on line 14.	16.	$

17. Use the amount on line 16 to determine eligibility.
18. On lines 19 and 21 enter the number of each month used for each period beginning with 1.
On line 20 enter the amount under the month, a lump sum payment is expected.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
19. Averaging Period												
20. Lump Sum Payment												
21. Certification Period												

Signature: _____ Date: _____

(Certification Clerk)

Attach to DPHHS-FD-001

DPHHS-FD-012
(Rev. 3/09)

STATE OF MONTANA
Department of Public Health and Human Services
Human and Community Services Division
Food Distribution Section

RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name: _____ Social Security Number: _____

Address: _____
(Street) *(City)* *(State)* *(Zip Code)*

I authorize the individual, company or agency shown below to disclose to the Needy Family Program Commodity Office, the information specified below, which relates to my eligibility to receive Public Assistance benefits. I understand any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of benefits or services. I further understand that any information obtained may be released to a proper governmental agency or court of law enforcement agency for purposes of legal and investigative actions concerning fraud, collection of support or establishment of third party liability.

INFORMATION SHOULD BE RETURNED TO THIS ADDRESS	

INFORMATION SOURCE:

INFORMATION TO BE REQUESTED:

INSTRUCTIONS:

This is a 4-page N.C.R.
Send one (1) copy to each information source.
Keep at least one (1) copy in the client's file.

Signature of applicant or person signing in his/her behalf:

X_____ Date: _____

Public Health & Human Services – PO Box 202956, Helena MT 59620-2956

In accordance with federal law and USDA 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 Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800)795-3272 (voice) or (202)720-6382 (TDD). USDA is an equal opportunity provider and employer.

DPHHS-FD-001C NEW 04/00

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

PENALTIES FOR INTENTIONAL PROGRAM VIOLATIONS

(EFFECTIVE FEBRUARY 28TH, 2000)

EFFECTIVE FEBRUARY 28TH, 2000 ANY APPLICANT OR HOUSEHOLD MEMBER KNOWINGLY, WILLINGLY, AND WITH DECEITFUL INTENT:

1) **MAKES A FALSE OR MISLEADING STATEMENT, OR MISREPRESENTS, CONCEALS, OR WITHOLDS FACTS IN ORDER TO OBTAIN FOOD DISTRIBUTION BENEFITS WHICH THE HOUSEHOLD IS NOT ENTITLED TO RECEIVE; OR**

2) **COMMITS ANY ACT THAT VIOLATES A FEDERAL STATUTE OR REGULATION RELATING TO THE ACQUISITION OR USE OF FOOD DISTRIBUTION PROGRAM COMMIDITIES;**

3) **WILL BE INELIGIBLE TO PARTICIPATE IN THE FDPIR PROGRAM FOR:**

   a) **12 months for the first violation:**
   b) **24 months for the second violation:**
   c) **Permanently for the third violation.**

ALL SUBSTANTIATED CASES OF (IPV) INTENTIONAL PROGRAM VIOLATION MUST BE REFFERRED TO TRIBAL, FEDERAL, STATE, OR LOCAL AUTHORITIES FOR PROSECUTION UNDER APPLICABLE STATUTES.

I HAVE READ AND FULLY UNDERSTAND THE PENALTIES FOR THE ABOVE VIOLATIONS.

NAME OF APPLICANT (PLEASE PRINT):_____

SIGNATURE OF APPLICANT:_____

SIGNATURE DATE:_____

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

STATEMENT OF NO INCOME

I, _____ HAVE HAD NO INCOME FROM_____TO_____
DURING THIS TIME, I WAS ABLE TO FIND FOOD, SHELTER, AND BASIC
NEEDS ETC. BY EXPLAIN: _____

_____

_____

_____

I ATTEST THAT THE ABOVE INFORMATION STATED IS TRUE AND CORRECT,
AND UNDERSTAND THAT THE ABOVE INFORMATION, IF MISREPRESENTED
OR INCOMPLETE MAY BE GROUNDS FOR IMMEDIATE TERMINATION FROM THE
PROGRAM AND/OR PENALTIES AS SPECIFIED BY LAW.

SIGNATURE OF CLIENT_____

DATE_____

OFFICIAL USE ONLY

NAME OF AGENCY_____DATE_____

PROGRAM_____CERTIFICATION OFFICIAL_____