



Seneca Nation

Food Distribution Program

210 Thomas Indian School Drive Ext. Irving NY 14081

Ph: 716.532.1028 / Fax: 716.532.8323

Eligibility Requirements

- Household must reside within the jurisdictional boundaries of the Seneca Nation.
- Households' income cannot exceed income eligibility standards developed by the USDA.
- Households cannot participate in the Food Distribution Program (FDPIR) and the Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program.

Documents Needed

Proof of enrollment

Provide proof of enrollment in a Federally Recognized tribe (to those it pertains to) for at least one household member

Residential Verification

A current utility bill, phone bill or rent receipt with applicant's name and residential address. We are looking for verification of physical address to verify that you live within the Seneca Nation jurisdictional boundaries. Please note, mailing addresses with a P.O Box does not verify your physical address.

Verification of Income

Four (4) recent pay stubs, social security, retirement, unemployment, etc. for ALL household members over the age of 18. Household members 18+ with no income must fill out the zero/low-income verification form. Self-employed individuals must submit their most recent tax form.

Verification of Identity

Copy of social security cards for all household members

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities based on race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write a letter addressed to USDA, and mail to: U.S. Dept of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Ave, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider.

Food Distribution Program on Indian Reservations (FDPIR)

Written Notice of Beneficiary Rights

Name of Organization: **Seneca Nation Food Distribution Program**

Because FDPIR is supported in whole or in part by financial assistance from the Federal Government, we are required to let you know that:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html 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
Washington, D.C. 20250-9410;
2. fax: (202) 690-7442; or
3. email: program.intake@usda.gov

This written notice must be given to you before you enroll in FDPIR or receive services from the program, unless the nature of the service provided or exigent circumstances make it impracticable to provide such notice before we provide the actual service. In such an instance, this notice must be given to you at the earliest available opportunity.

This institution is an equal opportunity provider.



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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: _____ Telephone No: _____
Physical Address: _____
Mailing Address (if different): _____
City/State/Zip Code: _____ County: _____ Household size: _____
Directions to home (delivery): _____

HOUSEHOLD MEMBERS: Complete the following for each member of your household. Your household means yourself and the people who live with you. List yourself 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 #
1.			
2.			
3.			
4.			
5.			
6.			

Are you or anyone in your household currently receiving SNAP (formerly Food Stamp Program) ? ☐ Yes ☐ No

Have you or anyone in your household recently applied for SNAP? ☐ Yes ☐ No List Name(s): _____

Have you or anyone in your household been disqualified from SNAP for an intentional program violation? ☐ Yes ☐ No

If yes, list names: _____

Income (Earned & Unearned): List income from all sources for each household member wages, social security, SSI, TANF, general/public assistance, foster care payments, child support, unemployment, work/training allowances, etc. **Verification of income is required for all household member** (pay stubs, award letters, etc.) Households with earned income must provide a full month's (4weeks) wage statements. Attach a separate sheet, if you need to list additional household members.

Household Member	Employer / Source of Income	Type of Income (wages, SS, child support, TANF, etc.)	Net Amount	How Often Paid Weekly, Bi-Weekly, Monthly
1.				
2.				
3.				

Self-Employment Income: Payments from rental property, roomers, farming, ranching, and/or operating a business is considered to be Self-Employment. Please provide a copy of last years Tax form, if applicable or other proof of Self-Employment costs and income.

Name	Type of Business	Amount	How Often Paid Weekly, Bi-Weekly, Monthly
1.			
2.			

Students: Are there any students in your household who receive education grants, scholarships or loans? YES ☐ NO ☐ if yes, complete and please provide verification.

Household Member	Amount of Loan / Grant	Attending Month/Year TO Month/Year	Type of Payment	Amount used to pay Tuition/School Fees

Authorized Representative: To authorize someone outside your household to pick your food, complete this section.

Name (s)	Address	Telephone Number

Allowable Deductions [Please provide verification]

STANDARD SHELTER/UTILITY EXPENSE: Does anyone in your household pay, on a monthly basis, at least one shelter/utility expense? ☐ YES ☐ NO

If yes, what type of shelter/utility expense (s) are paid monthly: _____

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? ☐ YES ☐ NO If yes, name and address of child care provider: _____

Amount Paid: \$ _____ How often paid: (daily, weekly, monthly, etc.) _____

CHILD SUPPORT: Does anyone in your household pay court ordered child support for non-household member? ☐ YES ☐ NO

If yes, complete the following: Amount ordered to pay: \$ _____ Amount actually paid: \$ _____

EXCESS MEDICAL EXPENSES: Anyone in your household elderly and/or disabled? ☐ YES ☐ NO if yes, all elderly and/or disabled household members may deduct medical expenses, excluding special diets, in excess of \$35 a month. Monthly total of excess medical expenses: \$ _____

RACIAL/ETHNIC HERTIAGE: This information is voluntary. If you do not provide this information, it will not effect your eligibility

1. Are you Hispanic or Latino? Choose one of the following: ☐ YES or ☐ NO

2. What is your race? Choose any of the following that apply: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

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 represented by a household member or representative, such as a legal counsel, a relative, a friend or other spokesperson.

PENALITY WARNING: If your household receives USDA 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 attempt to make false or misleading statements, misrepresent, conceal, or withhold facts regarding income, household size, and/or participate in the Supplemental Nutrition Program (SNAP) in order to obtain Food Distribution Program benefits which your household is not entitled to receive.
2. Do not trade or sell USDA foods.
3. Do not use someone else's commodity foods.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: If you or any member of your household knowingly and willing 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 institution, 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 the information contained in it is true to the best of my knowledge. I understand that I must comply with Program rules and provide additional documentation if required, and the falsification of information on this form may be grounds for disqualification and/or claim action. I further understand that I must report within ten (10) calendar days after the change becomes know the following changes: a change in household size or composition; and increase in net monthly income of more than \$100; a change in residence/address; when the household not longer incurs a shelter or utility expense; or a change in legal obligation to pay child support.

APPLICANT'S SIGNATURE: _____

DATE: _____

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RELEASE OF INFORMATION CONSENT FORM

The Seneca Nation Food Distribution Program is requesting your permission to verify your application and income information with the Erie, Chautauqua and Cattaraugus County SNAP department and/or Social Security Administration. To document your application, we are also requesting permission to periodically examine the applicant and any household members listed on the application.

DUAL PARTICIPATION:

No household on the Cattaraugus or Allegany Reservations or surrounding urban areas shall be permitted to participate in the Food Stamps and Food Distribution Program simultaneously.

This information is required by Federal, State and Local Regulations to be maintained by the Food Distribution Program.

STATEMENT:

I have read and understand the above statement and give my consent to the conditions described by the Seneca Nation Food Distribution Program.

DO YOU CURRENTLY RECEIVE SOCIAL SECURITY INCOME? YES NO

DO YOU CURRENTLY RECEIVE SNAP (FOOD STAMPS) BENEFITS? YES NO

I, _____, residing at _____,
do hereby authorize the Erie, Chautauqua, and Cattaraugus County Department of TANF and/or Social Security Administration to release ALL information concerning the current status and/or benefits of my case.

Date of Birth: _____ Last 4 digits of Social Security #: _____

Applicant Signature: _____ Date: _____

Application cannot be processed without a signature.



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HOUSEHOLD ZERO / LOW INCOME

Client Name: _____

PART 1. For PART 1, complete either section A OR section B.

A. I have had NO source of income since _____

Date of last employment: _____

Place of last employment: _____

Reason for leaving: _____

Have you applied for Unemployment Benefits? YES NO

Are you receiving Unemployment Benefits? YES NO

B. MY ONLY SOURCE(S) OF INCOME ARE:

SOURCE	DATE RECEIVED	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART 2. Complete all questions below.

Explain how your basic necessities have been provided.

1. Food: _____

2. Personal items: _____

3. Shelter: _____

4. Utilities / heating bills: _____

5. Transportation: _____

I certify that the information contained on the worksheet is accurate and true to the best of my knowledge. False information could result in ineligibility.

Client Signature _____ Date: _____