



Seminole Nation Food Distribution & Nutrition Services
 P.O. Box 111
 Seminole, OK 74818-0111
 405-382-3900 or toll-free 866-571-3900
 Fax # 405-382-3305

New _____ Recert _____
 Application Date: _____

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.
IMPORTANT: When returning your application, please bring proof of all household income – for example, pay stubs, award letters for government benefits such as SSI or Social Security, etc. and proof of residence (Utility bill with name and address dated within the last 30 days). In addition, at least one member of the household must provide a Certificate of Degree of Indian Blood (CDIB) card or a tribal enrollment card.

Name (Head of Household): _____
Address: _____
City/State/Zip: _____
County: _____
Phone: _____

HOUSEHOLD MEMBERS: List all the members of your household. List your name first. (Attach additional names on a separate sheet, if needed). Please Print.

NAME(S) of all Household Members (Last, First, Middle Initial)	RELATIONSHIP TO HEAD OF HOUSEHOLD (spouse, daughter, son, cousin, etc.)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.			
2.			
3.			
4.			
5.			
6.			

Are you or anyone in your household currently receiving SNAP? Yes No
 If yes, list names: _____
Have you or anyone in your household recently applied for SNAP? Yes No
 If yes, list names: _____
Have you or anyone in your household been disqualified for an intentional program violation under the SNAP?
Yes **No** If yes, list name(s): _____

INCOME: List all income from all sources for each household member (wages, public assistance, social security, foster care payments, unemployment or worker's compensation, child support, SSI, Oil royalties, Veterans benefits, pensions or retirement, per capita payments from gambling enterprises, etc.). List Gross Amount (amount before deductions).

NAME(S)	TYPE OF INCOME (Wages, Unemployment, Pensions Social Security, TANF, etc)	SOURCE OF INCOME (Name of Employer, Social Security Admin., VA, etc)	GROSS AMOUNT & HOW OFTEN PAID (Monthly, Bi-wkly, Weekly)

SELF-EMPLOYMENT INCOME: Are there any members in your household who are self-employed? Yes No
 Payment from rental property, roomers, boarders, farming, ranching, and/or operating your own business is considered to be self-employment. If self-employed, please complete the following and 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.

NAME(S)	TYPE OF BUSINESS	AMOUNT REC'D/HOW OFTEN PAID	COST OF PRODUCING SELF-EMPLOYMENT

STUDENTS: Are there any students in your household who receive education grants, scholarships or loans? Yes No
 If yes, complete the following section.

NAME(S)	NAME OF SCHOOL	AMT. OF GRANT, LOAN, OR SCHOLARSHIP	AMT. USED TO PAY TUITION & FEES	FROM MO/YR TO MO/YR

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

NAME(S)	CASH ON HAND	CHECKING/SAVINGS ACCOUNT	STOCKS, BONDS, CERTIFICATE OF DEPOSIT, OTHER

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 nonhousehold member? Yes No If yes, please list: **Amount Legally 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, complete the following: Household member: _____
 Amount paid for Part B: _____ Amount paid for Part D: _____

AUTHORIZED REPRESENTATIVE: To authorize someone outside your household to pick up your food, complete the information below.

NAME(S)	ADDRESS	TELEPHONE NUMBER

RACIAL/ETHNIC DATA COLLECTION: This information is voluntary. If you do not provide this information, it will not affect 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
 White Black or African American Native Hawaiian or Other Pacific Islander Asian

FAIR HEARING: If you disagree with any action taken on your household's case, you or your representative may request a fair hearing in writing or orally. Your case may be presented by any person you choose.

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 SNAP 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 or use someone else's commodity food.
3. Do not participate simultaneously in the Supplemental Nutrition Assistant Program and the Food Distribution Program.

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.

INITIALS _____ 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 or income/resources to the Food Distribution Office within **ten days** of the date the change becomes known.

Applicant's Signature _____ **Date** _____