

CRIT FOOD DISTRIBUTION PROGRAM REQUIREMENTS & APPLICATION

SERVICE AREA & WHO CAN APPLY

We serve anyone **Native American & NON Native American** living on the **CRIT reservation** which includes the county of La Paz, San Bernardino, Earp and Riverside

We also serve **25 mile radius off the reservation** but at least **ONE household member MUST be a tribal member of any federally recognized tribe with proper identification**



APPLICANTS CAN NOT PARTICIPATE IN SNAP/FOODSTAMPS/CALFRESH & FOOD DISTRIBUTION IN THE SAME MONTH
it is our policy to verify all participants prior to approval

DOCUMENTS REQUIRED THAT APPLIES TO YOUR HOUSEHOLD

- **IDENTIFICATION:** Valid Driver's License, Social Security Card, Picture State ID, Resident Alien Cards (if Applicable), Tribal ID or CIB (If Applicable)
- **ZERO INCOME:** Anyone over 18 fill out zero income form available from certifier.
- **SOCIAL SECURITY INCOME:** SSA, SSI, SSD, VA, RETIREMENT, - Proof of monthly deposit either yearly award letter or current/last month's bank statement of deposit.
- **WAGES:** Complete month of check stubs all members 18 and over.
Bi-weekly - 2 check stubs / Weekly - 4 Check stubs
- **UNEMPLOYMENT/WORKMAN'S COMP:** Letter of weekly deposit statement or 4 whole month's checks.
- **COLLEGE STUDENTS:** Any college students receiving school grants/loans FAFSA, PELL etc. Award letter for amount for the certain period and statement of school deductions (tuition, books, classes etc.)
- **SELF EMPLOYMENT:** Tax records for the current or previous year.
- **UTILITY BILL:** to verify you live in our service area, also we can use one bill for standard utility deduction if over the income or ALL qualified bills for the month (electric, water, trash, sewer, rent, phone bill etc.) ASK FOR MORE DETAILS
- **CHILD CARE /CHILD SUPPORT:** If paying for child care we can use this also as a deduction.. Must have court order of required child support monthly payments.
- **MEDICAL EXPENCE (ELDERLY OR IF APPLICABLE): DEDUCTABLE EXPENCES EXCEEDING \$35 A MONTH -** Dental, Vision, Hearing, prescriptions, out patient treatment, medical premiums etc.

Any questions or uncertain on any of this information please call and ask Certifier. We have 1-7 business days to process and complete applications once submitted.

MONTHLY INCOME GUIDELINES: Effective October 1,2025 - September30, 2026

- Household size 1: \$1,514
- Household size 2: \$1,972
- Household size 3: \$2,430
- Household size 4: \$2,903
- Household size 5: \$3,399
- Household size 6: \$3,895

For each additional person add \$459.

contact us

✉ 12302 Kennedy Drive

Parker, AZ 85344

☎ 928-575-1191

📍 13951 2nd Ave & Mohave Road (Next to Manataba Park)



APPLICATION

CRIT DHS FOOD DISTRIBUTION PROGRAM

Physical; 13951 2nd Ave & Mohave (Next to Manataba Park)
 Mailing: 12302 Kennedy Drive, Parker, Arizona 85344
 Telephone Number: (928) 575-1191



OFFICIAL USE ONLY
 Date Application Received
 FDP _____

- _____ New Application
- _____ Re Apply
- _____ Recertification
- _____ Update Application

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): _____ Mailing Address: _____ City/State/Zip Code: _____ Physical Address: _____	County: <u>Circle</u> ONE Household Size: _____ Telephone No.: _____ Message/Cell Phone: _____	La Paz / San Bernardino / Riverside _____ _____ _____
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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 <i>(Last, First, Middle Initial). Please Print.</i>	RELATIONSHIP TO HEAD OF HOUSEHOLD <i>(Self, spouse, daughter, son, cousin etc.)</i>	DATE OF BIRTH	SOCIAL SECURITY #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

*Are you or anyone in your household currently receiving SNAP benefits? Yes No If yes, list names: _____

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

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

INCOME (EARNED & UNEARNED): Yes No **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.**

List income from all sources for **each** household member including wages, social security, SSI, SSD, TANF, general/public assistance, foster care payments, unemployment or worker's compensation, child support, alimony, pensions, veteran's benefits etc.

Attach a separate sheet, if you need to list additional household members.

HOUSEHOLD MEMBER	Employer/ SOURCE OF INCOME	TYPE OF INCOME <i>(Wages, Social Security, TANF, Child Support, etc.)</i>	GROSS AMOUNT	HOW OFTEN PAID <i>Monthly, Bi-weekly, Weekly</i>

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 <i>(Farm, Ranch, Rental, Day care, etc)</i>	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/Other Rel. Exp.

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, type of shelter/utility expense paid monthly: RENT WATER/ELECTRIC CELL/TELEPHONE

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 pay court ordered child support for a 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, complete the following: **Monthly total of medical expenses**, excluding special diets: \$ _____

AUTHORIZED REPRESENTATIVE: To authorize someone outside your household to act on your behalf and/or pick up your food, complete this section.

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. What is your ethnic category? Hispanic or Latino **or** Not Hispanic or Latino

2. What is your race? American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White

Please read the following before signing application

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 USDA foods, 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 Supplemental Nutrition Assistance Program (SNAP) in order to obtain Food Distribution Program benefits which your household is not entitled to receive.
2. Do not misuse (e.g., trade or sell) USDA foods.
3. Do not participate simultaneously in the Supplemental Nutrition Assistance Program (SNAP) and the Food Distribution Program.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: 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 within ten (10) calendar days after the change becomes known the following changes: a change in household size or composition; an increase in gross monthly income of more than \$100; a change in residence/address; when the household no longer incurs a shelter pr utility expense; or a change in the legal obligation to pay child support.**

APPLICANT'S SIGNATURE: _____ DATE: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or
2. fax:
(833) 256-1665 or (202) 690-7442; or
3. email:
FNSCIVILRIGHTSCOMPLAINTS@usda.gov (DO NOT EMAIL APPLICATION TO THIS EMAIL)

This institution is an equal opportunity provider.