DPHHS-FD-001
(Rev. 11/26)

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. | SS#

Racial Ethnic Heritage: Enter number of household members in each category. You are not required to enter this information; however, this data is important for program evaluations. If you decline to provide this data, it will not affect your application.

American Indian/Alaskan Native I _____
White (Non-Hispanic) W_____ Black (Non-Hispanic) B_____
Hispanic H _____ Asian (or Pacific Islander) A_____

Is any member of this household currently certified to receive Supplemental Nutrition Assistance (SNAP)? ☐ Yes ☐ No

Is any member disqualified from the SNAP Program because of fraud, or disqualified from 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? _____

Monthly Shelter & Utility Expenses	
Rent/Mortgage	☐ Yes ☐ No
Property taxes	☐ Yes ☐ No
Electricity	☐ Yes ☐ No
Gas/Propane	☐ Yes ☐ No
Sewer	☐ Yes ☐ No
Trash Collection	☐ Yes ☐ No
Phone	☐ Yes ☐ No
Septic Maintenance	☐ Yes ☐ No

Monthly non-reimbursed out-of-pocket medical expenses over $35

Medical/Dental Prescriptions
Ins/Medicare premiums
Home Health Care Medical related transportation

See the certification clerk for the complete list of allowable deductions

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

Status Codes: M – Moved D – Deceased I – Ineligible S – SNAP 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

PENALTY WARNING: Your household must follow the rules below if you receive USDA foods. 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.
2. Do not trade, sell, or otherwise misuse USDA foods.
3. Do not participate in both the Supplemental Nutrition Assistance Program (SNAP) and the Food Distribution Program in the same month.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES: If you or any member of your household knowingly and willfully 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 the authorities for prosecution.

If you disagree with any action taken on your case, you or your representative has 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.

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.

ANY 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: 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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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: USDA Food and Nutrition Administration, George Washington Carver Center, 5601 Sunnyside Avenue, Beltsville, MD 20740; or (2) email: FNACIVILRIGHTSCOMPLAINTS@usda.gov.

This agency and USDA are an equal opportunity provider, employer, and lender.

APPLICANT: READ ABOVE AND COMPLETE THE SECTION BELOW

I hereby authorize the following individuals to act as my Authorized Representatives: (optional)

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 with the 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

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

1. Household has no income nor anticipates any for the current month.
2. All household members received an AFCD or SSI grant.

If the household has no income, 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

CERTIFICATION ACTION

Status Codes: M – Moved D – Deceased I – Ineligible S – SNAP X – Delete

Status Code Date: _____ Status Code: _____

APPROVED from: _____ through _____

DENIED (Reasons): _____

Signature: _____ Date: _____
(Certifying Clerk)

CHECK APPROPRIATE BOX(ES)	Approved for expedited services	
	☐ Yes	☐ No

DPHHS-FD-0001A PART II INCOME STATEMENT	☐ Yes	☐ No
DPHHS-FD-0001B PART III VERIFICATION INFO	☐ Yes	☐ No

DPHHS-FD-0001A
(Rev. 2/26)

PART II INCOME STATEMENT
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 Section 4720-4727)

List all *gross income before taxes from self-employment, to include payment 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 $
A. ENTER TOTAL HERE		$		D.	**Total to average $**

Lis all *net profits* from the sale of capital goods or equipment within the last 12 months and enter dates of sale

ITEMS	AMOUNT	DATE		FOR OFFICE USE ONLY
	$			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

ITEMS	AMOUNT	DATE		FOR OFFICE USE ONLY
Labor	$			Amount to average $
Stock and 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 $
C. ENTER TOTAL HERE	$		F.	**Total to average $**

FOR OFFICE USE ONLY

If income listed in Subsection A-1 is the household's 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 household's 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 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

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

SUBSECTION A-2 TRAINING ALLOWANCES (Reference FNS 501 Section 4520C)

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

SUBSECTION A-3 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 FNS501 Section4261)	Total monthly wage and salary income and enter the total on this line:						$

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(Rev. 2/26)

PART II INCOME STATEMENT

Department of Public Health and Human Services

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

Section B Unearned Income (Reference FNS 501 Section 4530)

SOURCE OF INCOME

1. SSI (Supplemental Security Income)-Gold Checks	9. Other (Specify)
2. AFCD (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 relative (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 – 2.5 – 4 – 4.3	
				1 – 2 – 2.5 – 4 – 4.3	
				1 – 2 – 2.5 – 4 – 4.3	
				1 – 2 – 2.5 – 4 – 4.3	
				1 – 2 – 2.5 – 4 – 4.3	
				ENTER TOTAL $	

Section C Income Deductions

If you pay for childcare 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.

Recurring monthly out of pocket medical deduction-over $35	$
Legally required child support payments	$
Premium for Medicare Part B	$
Housing/Utility standard deduction ($550)	$
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 on reverse side	9. $
10.	Add lines 7, 8, and 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.	One line 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 _____

DPHHS-FD-001B
(Rev. 11/2026)

STATE OF MONTANA
Department of Public Health and Human Services (Rev.

CASE NUMBER:

NAME: _____
(Head of Household)

PART III - VERIFICATION INFORMATION

Please document how information on the Food Distribution Application, DPHHS-FD-001, was verified and attach this form and any additional supporting documentation to the Application. Document the names of any collateral contacts made regarding the household and the date the contact was made.

A. **RESIDENCY** Date Verified: _____
How Verified: _____
_____

B. **IDENTITY** Date Verified: _____
How Verified: _____
_____

C. **RESOURCES** Date Verified: _____
How Verified: _____
_____

D. **INCOME** Date Verified: _____
How Verified: _____
_____

E. **OTHER** Date Verified: _____
How Verified: _____
_____

REMARKS: Note additional remarks or information needed on the Application or Income Statement:

_____
_____
_____

Signature: _____ Date: _____
(Certification Clerk)

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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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This institution is an equal opportunity provider.

DPHHS-FD-001C
(REV 2/26)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS

PENALTIES FOR INTENTIONAL PROGRAM VIOLATIONS

(EFFECTIVE 2/28/00)

Any applicant or household member that knowingly, willingly, and with deceitful intent:

1) Makes a false or misleading statement, or misrepresents, conceals, or withholds 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 commodities;

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; and
   c) Permanently for the third violation.

All substantiated cases of (IPV) intentional program violations must be referred 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****

DPHHS-FD-012
(Rev. 12/19)

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

RETURN TO FDPIR OFFICE BY:

FDPIR applications must be processed within seven (7) calendar days (excluding weekends and holidays) after application is filed.
USDA FNS 501 Handbook, Section 3300

VERIFICATION OF SNAP BENEFITS

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

Clients may not receive Supplemental Nutrition Assistance Program (SNAP) and Food Distribution on Indian Reservations (FDPIR) benefits at the same time.

THE FOLLOWING CLIENT HAS APPLIED FOR FDPIR BENEFITS. PLEASE VERIFY THE CLIENT'S SNAP STATUS AND RESPOND TO THE FDPIR OFFICE LISTED BELOW.

Client's Name: _____ Social Security Number: _____

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

List all Household Members

Name	SSN

OPA Office Use Only

Is the client or any household member receiving SNAP?

Circle one: Yes No

If Yes, please provide household member's name and last date of receiving SNAP benefits?

Name	Date

OPA Staff Name: _____

Date Completed: _____

Please return information to the following address:

Phone:
Fax:
Email:

FDPIR Certifying Official: _____ Date form sent to OPA Office: _____

I authorize the above individual, company or agency to disclose to the Food Distribution on Indian Reservations (FDPIR) office the information specified above, 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.

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

X _____ Date: _____

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

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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 institution is an equal opportunity provider.

CONFEDERATED SALISH & KOOTENAI TRIBES

CONSENT FOR RELEASE OF INFORMATION

I/We, the undersigned are seeking services from the Department of Human Resources Development (DHRD) which includes, but is not limited to the following programs: 477 Programs including Child Care Block Grant, TFAP Cash Assistance, Commodities, Dire Need, WIOA, SYEP, LIHEAP, NEW, General Assistance, FEMA, Indian Elderly Program, Vocational Rehabilitation Program, Warming Center, Anchor Way and Pablo Small Home Transitional Housing, Tribal Social Services, and other emergency housing resources.

I/We, authorize the above-named programs to share, exchange, give, and receive information about my application and contents therein, in an effort to serve me, my family and my children (as declared on my application/applications for assistance).

In addition, I/We authorize the following programs/agencies to release and share information to the DHRD Program in an effort to provide and facilitate assistance to my/our children and myself/ourselves. Those programs and agencies include but are not limited to the following: INITIAL EACH DEPT. YOU AUTHORIZE TO RELEASE INFORMATION.

1. _____ Tribal Personnel Office: (Drug Test results), etc.
2. _____ Early Childhood Services – ECS – Participation in services (CHIP information, Address, Household Composition)
3. _____ Tribal Health and Human Services - THHS (Mental Health, Family Support, Alternate Resource), etc.
4. _____ Tribal Education Department – TED (educational awards, grades, referrals), etc.
5. _____ Salish Kootenai College/ALC/ABE Programs – (Schedule, Test results, Student verification of attendance, Credit Loan, Grants), etc.
6. _____ Montana State Offices of Public Assistance – (Flathead, Lake, Missoula, Sanders County)
7. _____ Salish Kootenai Housing Authority – SKHA (eligibility, rent amount, bad debts, household compositions, lease compliance, residency), etc.
8. _____ S&K Holding – Welfare to work issues
9. _____ Public Schools – (verify attendance of minor children in general school and at IEP sessions)
10. _____ Tribal Police – (CPS referrals and outstanding warrants.), etc.
11. _____ Probation Adult/Juvenile – (Truancy, Community services and other requirements)
12. _____ Tribal Court – Community Services and Court Orders, Healing Court, etc.
13. _____ Tribal Lands Department (TLD) – (verify Land Lease), etc.
14. _____ Tribal Prosecutors / Tribal Defenders (CPS, Court Orders, Truancy, Families at Risk Staffing), etc.
15. _____ MT Children's Health Insurance Program (CHIP) – Eligibility Status & Employee Health Insurance Information
16. _____ Tribal Enrollment – verify enrollment enrolled tribe _____
17. _____ Social Security Administration, MT Disability Bureau, Veteran's Administration – Verify income
18. _____ Workman's Compensation Programs (income verification, medical coverage)
19. _____ MT STATE SNAPPROGRAM/TRIBAL FOOD DISTRIBUTION PROGRAM Case Number _____
20. _____ CSKT Tribal Credit
21. _____ CSKT Tribal Council
22. _____ Homelessness Task Force Coordinator/Tribal Member Services Director/Anchor Way Case Manager
23. _____ NARSS Recovery Program
24. _____ Potential employers found by DHRD 477 programs. _____

I/We understand that the information received by the DHRD Programs will be kept confidential, used for professional purposes only in terms of facilitating services received by me and my/our family, and will not be released to other outside programs/agencies, unless prior authorization by me, in writing, is obtained. I/We understand the I/We may cancel this Consent for Release of Information, in writing at any time.

_____ _____

Print Name - Applicant/Parent or Guardian Date Sign Name Date

_____

Witness Date

THIS CONSENT FOR RELEASE OF INFORMATION IS VALID FROM _____ TO _____

THIS RELEASE OR REQUEST OF INFORMATION HAS BEEN REVOKED BY:

_____ _____

Applicant/Parent or Guardian Signature Date