



Ponca Tribe FDPIR

222 White Eagle Dr. • Ponca City, Oklahoma 74601
(580) 762-3443 • (580) 762-3437



Attention! We do not have jurisdiction and are not able to certify you if you live within the city limits of Ponca City, Stillwater, Enid and Guthrie!

Clients: The following information is needed to determine your eligibility for the Ponca Tribe FDPIR. Please be aware that we do have income guidelines that we have to adhere to and also a designated area that we can serve. You should not have an application pending with the Supplemental Nutrition Assistance Program (SNAP) and/or you should not have already received benefits with SNAP in the same month that you are making an application with this office. This is Dual Participation and is not allowed.

Proof of Tribal Membership: 1.) An official card, letter, or other documentation issued by an Indian Tribe which indicates that you are a tribal member.
2.) An official Certificate of Degree of Indian Blood or Certificate of Degree of Alaskan Blood (both abbreviated CDIB) card.
3.) An official document (letter, memorandum, form, etc.) from a Bureau of Indian Affairs office or a Tribe/Nation which states the individual named in the document is the direct descendant (son, daughter, grandchild, etc.) of a federal-recognized member.

Updated Verification of Income: We need proof of income for the past 30 days. If you receive Social Security or SSI, we'll need to see your award letters. All persons residing in the household over the age of 18 must provide proof of income or documentation of higher education. If unemployed, Collateral Statements of Unemployment are necessary.

Verification of Residence: A current utility bill is necessary. We need the portion of the bill that has the name on it. Electric, water or gas is preferred.

Social Security Cards: Social security cards if you have them.

We have tailgates the first 3 working days of each month at Newkirk (Johnny Ray McCauley gym), at Ft. Oakland (Enterprise Bldg.) and at the Otoe Complex (Cultural Center). These tailgate sites are for your convenience, if you cannot make it to the tailgate sites, our main office will be open thereafter.

"This institution is an equal opportunity provider and employer"



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Name (Head of Household) _____
Address _____
City/State/ Zip _____
Phone _____
E-Mail _____

HOUSEHOLD MEMBERS: List all the members of your household. List your name first. (Attach additional names on a separate sheet). **PLEASE PRINT.**

Names of all Household Members <i>First, Middle Initial, Last</i>	Relationship to Head of Household	Date of Birth	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or anyone in your household receiving Supplemental Nutrition Assistance Program (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 Supplemental Nutrition Assistance Program? Yes No If yes, list names: _____

INCOME: List all income from all sources for each household member (wages, public assistance, social security, foster care payments, unemployment or workers compensation, child support, SSI, per capita payments from gambling enterprises, etc.) **List gross amount.** (Amount before deductions).

NAMES	HOW OFTEN PAID	SOURCE OF INCOME	GROSS AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SELF-EMPLOYMENT INCOME: 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 years Federal Income Tax Form (1040, Scheduled F , C and E if applicable) or other of self-employment costs and income.

NAMES	TYPE OF BUSINESS	AMOUNT RECEIVED	HOW OFTEN PAID
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Names	Name of School	Amount	Amt. Used to pay Tuition/ Fees	From Mo. / Yr. To Mo. / Yr.
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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, the type of shelter/utility expense paid monthly. _____

Dependant Care: Does anyone in your household pay for the care of a child or other dependant when necessary for a household member to accept or continue employment or to attend training or to pursue education which is preparatory to employment? Yes No If yes, provide name and address of the person providing care.

Amount paid: _____ How often: _____

Child Support: Does anyone in your household pay legally required child support for a non-household member? (E.g. court ordered) Yes No If yes, please list amount specifically ordered to pay: \$ _____
Amount actually paid: \$ _____ How often: _____

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 this section. _____

Racial/ Ethnic Data Collection: This information is voluntary. If you do not provide this information, it will not affect your case. **1. What is your ethnic category?** ___ Hispanic or Latino or ___ Not Hispanic or Latino
2. What is your race? Choose any of the following. ___ American Indian or Alaska Native. ___ Asian. ___ Black or African American. ___ Native Hawaiian or Other Pacific Islander. ___ White.

Fair Hearing: If you do not agree with any action taken on your households' case you or your representative may request a fair hearing in writing or orally. Any person you choose may present your case.

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 with SNAP in order to obtain Food Distribution Program benefits, which your household is not entitled to.**
2. **Do not trade or sell commodity food.**
3. **Do not use someone else's commodity food.**

Intentional Program Violation (I.P.V.) Penalties: Household members determined to have committed an I.P.V. will be ineligible to participate in the 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 I.P.V. may be referred to authorities for prosecution.

Certification Statement: I certify 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, income and/or resources to the Food Distribution Office within **ten days** of the date the change becomes known.

I authorize the Ponca Tribe FDPIR to make any necessary investigation/ inquiry to verify the information given.

Applicants Signature: _____ **Date:** _____

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#1 RESIDENTIAL STATEMENT

This information is needed to determine eligibility with our program. All information will be kept confidential.

Present Address: _____
Mailing Address / Physical Address

City State Zip Code

I, _____ verify that _____
is not part of my household and prepares meals separately.

Name: _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Comments: _____

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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.



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#2 RESIDENTIAL STATEMENT

This information is needed to determine eligibility with our program. All information will be kept confidential.

PRESENT ADDRESS: _____
Mailing Address Physical Address

City State Zip Code

I, _____ verify that _____
does not live in my household but does receive mail in my mailbox.

Name: _____

Address: _____

Telephone #: _____

Signature: _____ Date: _____

Comments: _____

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#3 RESIDENTIAL STATEMENT

This information is needed to determine eligibility with our program. All information will be kept confidential.

Present Address: _____
Mailing Address _____ Physical Address _____

City State Zip Code

I, _____ verify that _____
does live at the address stated above, and that the utility bills are included in the rent received.

Name: _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Comments: _____

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#4 RESIDENTIAL STATEMENT

This information is needed to determine eligibility with our program. All information will be kept confidential.

Present Address: _____
Mailing Address _____ Physical Address _____

City _____ State _____ Zip Code _____

I, _____ verify that _____
lives on the same property but lives in a different dwelling.

Name: _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Comments: _____

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Client's Name: _____

This form is to be completed by two persons who are **not related to you**. They must state that they know the participant is unemployed, sign their name, date it and give their address and telephone number. This form is very important!

Collateral Statements of Unemployment

1. _____

Name Date

Address Telephone

2. _____

Name Date

Address Telephone

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ZERO INCOME

In determining your eligibility for the Food Distribution Program, you must provide proof of income for the thirty (30) days prior to the date of the application. If you had zero income for the past 30 days please answer the following questions.

1. What was the total income for the past three months? _____
2. How do you pay your utility bills? _____
3. How do you make rent/house/car payments? _____
4. How do you get food for your household? _____
5. Have you received income from friends/family? _____
6. Are you looking for employment? _____
7. Have you applied for Public Assistance or General Assistance? _____
8. If you are residing with others (such as family or friends), do you purchase, prepare and eat your meals separately? _____

I hereby certify that the information that I have provided, accurately represents the total income for each member of my household (18 years and older). I understand that I must report any changes in household size or income/resources within 10 days of the date the change becomes known.

Signature: _____ **Date:** _____

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