Attention Mille Lacs Band Food Distribution Clients

With NEW changes to the eligibility rules, please take note:

1. Households are now allowed a higher net monthly income, as shown in the guidelines.
2. There is a “shelter/utility” deduction that requires proof of a utility or rent bill. Be certain you have a copy to provide with your application.

Due to changes in tribal bonus payments, we now require FIVE (5) business days to process applications. Once eligibility has been determined, TWO (2) business days may be needed to place, process and receive your food order, this will depend mainly on the number of applications we have to process.

Bonus verification is required

Keep a copy of your bonus check stub or bank statement with your application. Office of Management and Budget (OMB) now requires a $5 processing fee for income requests.

We will no longer do same day pickups

Remember, when we make an appointment with you to receive your food order, this is our promise to you, we will be here. When you do not pick up your food order and do not notify us, we will not be held responsible for missed pick up. Missed appointments are an inconvenience to everyone.

Outer district clients: DI, DII, DIIA, and DIII

For clients who have missed their delivery pick-ups, we will bring your order back to the Mille Lacs Band Food Distribution warehouse where you may pick your order up. We will hold all undelivered order until the last two (2) days on the month; the orders will then be voided out and restocked. You may order again the following month if you are recertified.

Phone: 320-532-7880 Ext:227 or Fax: 320-532-7546

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**FNS HANDBOOK 501**

**EXHIBIT M**

**FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR)**

**FY 2017 NET MONTHLY INCOME STANDARDS**

**(Effective October 1, 2016 to September 30, 2017)**

The net monthly income standard for each household size is the sum of the applicable Supplemental Nutrition Assistance Program (SNAP) net monthly income standard and the applicable SNAP standard deduction.

48 contiguous United States: **Use this amount**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Household  Size | SNAP Net Monthly  Income Standard |  | SNAP Standard  Deduction |  | FDPIR Net Monthly Income Standard | |
| 1 | $990 | + | $157 | = | $1147 | |
| 2 | $1335 | + | $157 | = | $1492 | |
| 3 | $1680 | + | $157 | = | $1837 | |
| 4 | $2025 | + | $168 | = | $2193 | |
| 5 | $2370 | + | $197 | = | $2567 | |
| 6 | $2715 | + | $226 | = | $2941 | |
| 7 | $3061 | + | $226 | = | $3287 | |
| 8 | $3408 | + | $226 | = | $3634 | |
| each additional member | | | | | +347 | |
|  |

Alaska: **Use this amount**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Household  Size | SNAP Net Monthly  Income Standard |  | SNAP Standard  Deduction |  | FDPIR Net Monthly Income Standard |
| 1 | $1237 | + | $268 | = | $1505 |
| 2 | $1669 | + | $268 | = | $1937 |
| 3 | $2100 | + | $268 | = | $2368 |
| 4 | $2532 | + | $268 | = | $2800 |
| 5 | $2964 | + | $268 | = | $3232 |
| 6 | $3395 | + | $282 | = | $3677 |
| 7 | $3827 | + | $282 | = | $4109 |
| 8 | $4260 | + | $282 | = | $4542 |
| each additional member | | | | | +434 |

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**FNS HANDBOOK 501**

**EXHIBIT M**

FY 2016 FDPIR Income Deductions (see 7 CFR 253.6(e))

Effective October 1, 2015 to September 30, 2016

|  |  |
| --- | --- |
| Earned Income Deduction | Households with earned income are allowed a deduction of 20% of their earned income. |
| Dependent Care Deduction | Households that qualify for the dependent care deduction are allowed a deduction of actual dependent care costs paid monthly to a non-household member. |
| Child support Deduction | Households that incur the cost of legally required child support to or for a non-household member are allowed a deduction for the amount of monthly child support paid. |
| Medical Expense Deduction | Households that incur monthly medical expenses by any household member who is elderly or disabled are allowed a deduction in the amount of out-of-pocket medical expenses paid in excess of 35$ per month. Allowable medical expenses are provided at 7 CFR 273.9(d)(3) |
| Home Care Meal-Related Deduction | Households who furnish the majority of meals for a home care attendant are allowed an income deduction equal to the maximum SNAP benefit for a one-person household. The home care meal-related deduction amounts are as follows:  48 Contiguous U.S States = $194  Alaska by Area Designations   * Urban = $237 * Rural 1 = $302 * Rural 2 = $368   See 7 CFR 272.7(b) for area designations in Alaska |
| Standard Shelter/Utility Expense Deduction | Households that incur at least one monthly shelter or utility expense are allowed a standard income deduction (see chart below). Allowable shelter/utility expenses are provided at 7 CFR 273.9(d)(6)(ii) |

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**FNS HANDBOOK 501**

**EXHIBIT M**

FY 2016 FDPIR Standard Shelter/Utility Expense Deductions

Effective October 1, 2015 to September 30, 2016

Baseline by Region\*

|  |  |  |
| --- | --- | --- |
| Region | States Currently with FDPIR Programs | Shelter/Utility Deduction |
| Northeast/Midwest | Michigan, Minnesota, New York, Wisconsin | $400 |
| Southeast/Southwest | Mississippi, New Mexico, North Carolina, Oklahoma, Texas | $300 |
| Mountain Plains | Colorado, Kansas, Montana, Nebraska, North Dakota, Utah, Wyoming | $400 |
| West | Alaska, Arizona, California, Idaho, Nevada, Oregon, Washington | $350 |

\*If the geographic boundaries of an Indian reservation extend to more than one region per the identified regional groupings above, then a qualifying household has the option to receive the appropriate shelter/utility expense deduction amount for the state in which the household resides or the state in which the state agency’s central administrative office is located.

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Mille Lacs Band of Ojibwe

Food Distribution Program

43408 Oodena Dr.

Onamia, MN 56359

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print Clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you live on the reservation?

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES or NO

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directions to your home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household members:** Print YOUR name first then each household member. Be sure to include date of birth and social security number for each household member. We **cannot** serve anyone located in a town with a population over 10,000 (i.e. Brainerd).

|  |  |  |  |
| --- | --- | --- | --- |
| Household member  (Last, First, MI) | Relationship  (to head of household) | Dates of Birth | Social Security Number |
|  | Head of Household |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If you need additional space, you may use the back of this page or a separate piece of paper.

**Dual Participation**

If anyone residing in your home is participating in the Food Stamp Program or with any other SNAP or food distribution program your household is ineligible to receive services from the MLB Food Distribution Program.

Are you or anyone in your household currently receiving food stamps? (Please circle) YES or NO

If yes, list the name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you requested to end your Food Stamp participation? (Please circle) YES or NO

If you have requested to end your food stamp participation, please give the date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or anyone in your household recently applied for Food Stamps? (Please circle) YES or NO

If yes, list names and dates for each: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or anyone in your household EVER been disqualified by the Food Stamp Program for IPV (intentional program violation)? (Please circle) YES or NO

If yes, list names and the dates for each: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving assistance from any other SNAP or Food Distribution Program?

(Please circle) YES or NO

If yes, list where and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Reporting:**

Please list all individuals who are receiving income, and the individual’s relationship to the head of household.

The following are examples of income to be claimed/listed: (not limited to) Wages, loans, tribal per capita, tribal bonus payments, child support, social security payments, disability payments, VA payments, foster care assistance, pension, unemployment, survivor benefits, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| Household member | Relationship  (To head of household) | Income Source | Frequency  ( Monthly, weekly, bi-weekly) |
| 1. | Head of Household |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |

If more room is needed continue on the back of this sheet or use a separate piece of paper.

Please list any household members who are 18 years of age or older and do not receive income (these members must complete the attached financial report form). Mark as “N/A” if this does not apply to anyone in your household.

|  |  |
| --- | --- |
| Household member | Relationship (to head of household) |
|  |  |
|  |  |
|  |  |
|  |  |

**Self-employment income:** Payment from rental property, roomers, boarders, farming, ranching, and/or operating your own business and are considered self-employed. Please provide a copy of last year’s Federal Income Tax form, a copy of your P&L and balance sheet, or other written documentation of self-employment costs and income. Mark as “N/A” if this does not apply to your household.

|  |  |  |  |
| --- | --- | --- | --- |
| Household member  (and relationship to head of household) | Type of business | Amount | Frequency  (monthly, weekly bi-weekly |
|  |  |  |  |
|  |  |  |  |

**Students:** Are there any students in your household who receive education grants, scholarships, or loans? If yes complete this section. Mark as “N/A” if this does not apply to your household.

6

**Dependent care:** Household members under the age of 24 months are eligible to a dependent care deduction. Is there anyone under the age of 24 months in your household? (Please circle) YES or NO

If yes, please provide the following

1. Dependent’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount paid for child care $\_\_\_\_\_\_\_\_\_\_
2. Name and address of agency or individual providing the care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Amount due to the agency or individual: $\_\_\_\_\_\_\_\_\_\_

Payment schedule (weekly, bi-weekly, monthly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Attach documentation from the child care facility or individual.

**Authorized Representative**

In the event you or a member of your household are unable to receive your food package, please list another individual or individuals who may receive your food when you are unable to. Please note that the Food Distribution staff cannot sign for your food package and we cannot leave it for you. You or an authorized individual must receive your food package.

If you do not wish to designate anyone, mark as “N/A”

|  |  |
| --- | --- |
| Authorized Individual | Telephone Number |
|  |  |
|  |  |

**Please continue onto the next page and carefully review each statement**

7

Mille Lacs Band of Ojibwe Food Distribution Program

Financial Report Form

(One form per person)

In order to determine eligibility to participate in the Food Distribution Program, each household member 18 years of age or older must provide verification of income for the past 30 days. However if any household member 18 years of age or older does NOT receive income he/she must complete this form.

1. Did you receive any financial support (i.e. working for friend, neighbor, borrow, loan) during the last 30 days?

(Please circle) YES or NO

If yes, please explain the source(s) and the amount(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently seeking employment? (Circle one) YES or NO
2. Have you applied for Public Assistance or General Assistance? (Circle one) YES or NO
3. If you are residing with others, do you purchase, prepare and eat your food separately?

(Circle one) YES or NO

I hereby certify that the information I have provided above accurately represents the total income for myself, as an adult member of this household.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of household member

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

8

**Instructions:** The following releases of information are for household members who are of legal age. Household members 18 years of age or older must review the statements in this application as well as understand their rights before signing. This application cannot be processed without the signatures of all the household members of legal age.

**If you are the only person applying, or there are no additional household members of legal age then disregard this page.**

|  |
| --- |
| **Authorization for Release of information addendum**  As a member of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Household and as a household member of legal age, I hereby authorize any individual, corporation, society, governmental agency or department, bank or financial institution to disclose to the **Mille Lacs Band of Ojibwe** the following information concerning my affairs. Further, a copy of this document will serve as an original copy when needed. I also hereby authorize the **Mille Lacs Band of Ojibwe,** to share information concerning me with any Federal, State, Local, or Tribal Organization deemed necessary. |

|  |
| --- |
| **Non-Discrimination**  I understand the Non-Discrimination statement listed on the previous page. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of household’s legal name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head of household’s authorization signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s legal name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s authorization signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s legal name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s authorization signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s legal name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household member’s authorization signature Date

**Each household member of legal age who does not receive any source of income please complete the financial report form on the following page.**

9

**APPLICANTS:**

Do NOT complete any information on this page.

**For office use only**

To:

ᴑSocial Security Administration

ᴑMille Lacs Band of Ojibwe

\_\_\_ Office of Management and Budget

\_\_\_ Department of Labor

ᴑState or County Health & Human Services Department

\_\_\_ Food Stamp Program

\_\_\_ Child Support Verification

Send the request information to:

Mille Lacs Reservation Food Distribution Program

43408 Oodena Dr.

Onamia, Mn 56359

ATTN: Food Distribution Certifier

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Food Distribution Certifier Date

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Before you submit your application

**READ THIS PAGE**

Are you sending us everything we need?

Please use the checklist below to make sure.

|  |
| --- |
| \_\_\_\_\_ Did you fill out the entire application? |
| \_\_\_\_\_ Did you sign the application (page 4)? |
| \_\_\_\_\_ Did each household member 18 years of age or older sign the release form? |
| \_\_\_\_\_ Did you provide a copy of your Tribal I.D (front and back)? |
| \_\_\_\_\_ Did all household members provide current verification of income (i.e. social security award letter, VA award letter, child support, pension, disability, bank statement, etc.? |
| \_\_\_\_\_ Did all household members provide their past 30 day earnings statement? (check stubs are not accepted) |
| \_\_\_\_\_ Did all self-employed household members provide a copy of their earned income verification? |
| \_\_\_\_\_ Did each household member 18 or older with no income complete and sign a financial report form? |
| \_\_\_\_\_ Did you provide verification of your Tribal Per Capita payments? |

If anyone in your house is receiving food stamps, you are **not** eligible. Our staff will complete a food stamp check with the county you are residing in before we process your application.

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Office of Management and Budget

Income verification request

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am requesting a printout of my Per Capita/Payroll (circle one) income for the time frame (dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I would like this report to be sent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or I will pick it up.

I understand that OMB has 3(three) business days to produce this information for me.

I further agree that a 5.00$ processing fee will be withheld from my next check to cover the costs of providing this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment # or Employee #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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*The U.S department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all parts of an individual’s income derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the department. (Not all prohibited bases will apply to all programs and/or employment activities.)*

*If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at* [*http://www.ascr.usda.gov/complaint\_filinf\_cust.html*](http://www.ascr.usda.gov/complaint_filinf_cust.html) *or at any USDA office, or call (866)632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at*

***U.S Department of Agriculture Director***

***Office of Adjudication***

***1400 Independence Ave. SW***

***Washington D.C 20250-9410***

*You may also fax your letter to (202)690-7442, or email at* [*program.intake@usda.gov*](mailto:program.intake@usda.gov)*.*

*Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800)845-6136(Spanish)*

*For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP hotline number at (800)221-5689, which is also in Spanish or call the state information/hotline numbers found at this website* [*http://ww.fns.usda.gov/snap/contact\_info/hotlines.htm*](http://ww.fns.usda.gov/snap/contact_info/hotlines.htm)

*USDA is an equal opportunity employer.*

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