



## ***Oneida Food Card Program*** Monday - Friday 9:00 am - 11:00 am

**YOU MUST PROVIDE THE FOLLOWING VERIFICATION WITH EACH APPLICATION AND BEFORE DISTRIBUTION OF GIFT CARD:**

- Oneida Tribe of Indians of Wisconsin Enrollment-**at least one adult in household**
- Proof of residency in Brown or Outagamie County dated last 30 days
- Proof of all Household income for the last 30 days (earned or unearned)
- Enrollment of WI FOODSHARE program or ineligibility or USDA Commodities Program

**INCOME REQUIREMENT IS 175% OF FPL EFFECTIVE 7/1/2015**

| Household Size /Monthly Income       |                |
|--------------------------------------|----------------|
| 175% of FPL                          |                |
| Household Size                       | Monthly Income |
| 1                                    | \$ 1,716.45    |
| 2                                    | \$ 2,323.12    |
| 3                                    | \$ 2,929.78    |
| 4                                    | \$ 3,536.45    |
| 5                                    | \$ 4,143.12    |
| 6                                    | \$ 5,021.20    |
| 7                                    | \$ 5,662.54    |
| 8                                    | \$ 5,963.12    |
| For each additional person add \$537 |                |

# ONEIDA FOOD CARD PROGRAM

## Customer Application

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ SOC SEC # \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ ENROLLMENT # \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

Maiden Name or any other name you may be listed as: \_\_\_\_\_ Veteran:  Yes  No

Marital Status:  Single/Never Married  Married/Living Together  Married/Separated  Widowed  Divorced

Do you reside within Reservation boundaries?  Yes  No  
 Do you currently receive Food Share (food stamps)  Yes  No If yes, **Day** of Month You Receive: \_\_\_\_\_  
 Do you currently receive Commodities?  Yes  No If yes, **Week** of Month You Receive: \_\_\_\_\_

**LIST ALL MEMBERS OF THE HOUSEHOLD: (including yourself)**

| Full Name | Relationship | Social Security Number | Date of Birth | Enrolled/Tribe |
|-----------|--------------|------------------------|---------------|----------------|
| 1.        | Self         |                        |               |                |
| 2.        |              |                        |               |                |
| 3.        |              |                        |               |                |
| 4.        |              |                        |               |                |
| 5.        |              |                        |               |                |
| 6.        |              |                        |               |                |
| 7.        |              |                        |               |                |
| 8.        |              |                        |               |                |

SOURCE OF INCOME: \_\_\_ TANF/W2 \_\_\_ SSI \_\_\_ Social Security \_\_\_ Disability \_\_\_ Pension  
 \_\_\_ Employment \_\_\_ Unemployment \_\_\_ Child Support \_\_\_ Other \_\_\_\_\_

**INCOME: List ALL GROSS past monthly income, include Child Support and Unemployment**

| Name | Source of Income | Amount | How Often |
|------|------------------|--------|-----------|
|      |                  |        |           |
|      |                  |        |           |
|      |                  |        |           |

If no income, how do you pay your rent/utilities? \_\_\_\_\_

**Why did the income end? (Check all that apply) Date income ended:** \_\_\_\_\_

\_\_\_ Laid off from work      \_\_\_ Terminated from job      \_\_\_ Public Assistance ended  
 \_\_\_ Unemployment ended      \_\_\_ Non-compliance w/program      \_\_\_ Disability Benefits ended  
 \_\_\_ Cash job ended      \_\_\_ Child Support stopped      \_\_\_ Other \_\_\_\_\_

**ONEIDA FOOD CARD PROGRAM  
Customer Application and Agreement**

- Once a household has been certified as eligible to receive assistance, gift cards can be issued once in a 30 day period. Gift card issuance is based on the size of the household. Applications are valid for **one year**, and any changes to household must be reported within 30 days.
- Persons receiving Food Share or Commodities may apply/receive assistance from this gift card program three (3) weeks after they have received their allocation from their main program of assistance. (Verification will be required)
- The Gift Card Program is a supplemental source of assistance; it is not intended to be the sole source nor ongoing source of food for a household.
- Gift card distribution is available between the hours of 9 am – and 11 am daily, Monday through Friday (these are the same hours that other Food Pantries provide assistance).
- **Not allowed: Alcohol or Tobacco products, Chips, candy, soda, coffee, tea, energy drinks, sweet roll/donuts, juice boxes, paper products (toilet paper, plates/cups etc.), pet food/supplies.**
- **Failure to provide receipt within thirty (30) days, or purchase non-allowable items will result as follows; first offense verbal warning, second offense six (6) month suspension, third offense one (1) year termination from the program.**
- Any reported misuse of this card will result in termination.

**Cards reported lost or stolen will not be replaced**

I understand the information I have provided on this application may be shared with other agencies or programs which could assist me further. I further waive my rights to confidentiality should I choose to take my request to management levels above the program's administrative structure.

I consent to release any and all information necessary for the determination of benefits to be made on my behalf and understand this release may include information regarding income, salary, benefits and/or disability.

*The information I have provided on this application is true and accurate to the best of my knowledge and I understand that providing false statements or withholding information will be grounds for suspension.*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Eligible    Not Eligible    Pending \_\_\_\_\_   App Expire Date: \_\_\_\_\_

Tribal Id    Proof of Residency    FoodShare/Commots    Income: \_\_\_\_\_   FPL: \_\_\_\_\_

COMMENTS: \_\_\_\_\_