State of Hawaii
Commodity Supplemental Food Program (CSFP)
Proxy Form

This form may be used to authorize an individual to act as your authorized representative for CSFP if you are unable to pick up your CSFP box on the day of distribution.

*(Please complete this form and have your designated proxy present it at the distribution site with their valid state or federal issued photo ID.)*

I, ________________________________________________________, residing at the following address, ______________________________________________________________________,

Participant’s Name

address, ________________________________________________________________________,

Address

authorize ______________________________________________ to pick up a CSFP box on my behalf.

Name of Proxy

_____________________________________

Participant’s Signature                                      Date

STAFF USE ONLY

Client ID: ____________________________

Site Name: ____________________________  Staff Initials: ____________________________

Revised 05/2021

This institution is an equal opportunity provider.