

U.S. DEPARTMENT OF AGRICULTURE - FOOD AND NUTRITION SERVICE
RACIAL/ETHNIC GROUP PARTICIPATION
COMMODITY SUPPLEMENTAL FOOD PROGRAM
 FCS INSTRUCTION 113-2

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing regulation.
 (Instructions on reverse of last copy.)

1. STATE	2. STATE # <input style="width:50px;" type="text"/>	L/A# <input style="width:50px;" type="text"/>	NO. OF CLINICS <input style="width:50px;" type="text"/>
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3. REPORTING	LOCAL AGENCY NAME <input style="width:90%;" type="text"/>
	ADDRESS <input style="width:90%;" type="text"/>
	CITY <input style="width:90%;" type="text"/>
	STATE <input style="width:20px;" type="text"/> ZIP CODE <input style="width:50px;" type="text"/> TELEPHONE <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>

4. REPORTING YEAR: APRIL _____	ACTUAL NUMBER OF PARTICIPANTS FOR THE MONTH OF APRIL
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5. PARTICIPATION BY RACIAL/ETHNIC GROUP	(A) WOMEN	(B) INFANTS	(C) CHILDREN	(D) ELDERLY	(F) TOTAL
a. Black, not of Hispanic origin					
b. Hispanic					
c. Asians or Pacific Islander					
d. American Indian or Alaskan Native					
e. White, not of Hispanic origin					
f. TOTALS (See Instructions)					

DATE	TITLE	SIGNATURE
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INSTRUCTIONS

This report will be prepared annually covering the month of April.

LOCAL AGENCIES: *Shall forward the original and one copy to the State agency by the 7th day of July, retaining the second copy.*

STATE AGENCIES: *Shall determine that reports have been received from all local agencies and review all information prior to forwarding the original copy to the appropriate FCS regional office in time to reach that office no later than the 31st day of July. The duplicate copy form shall be retained and used for analysis in monitoring local agencies and State agency compliance with civil rights requirements.*

FCS REGIONAL OFFICES: *Shall determine that all local agency reports have been received from the State agencies and reviewed for completeness. The regional office shall enter all local agency information into the National Master database by the 19th day of September.*

Item 1 and 4 - Self Explanatory.

Item 2 - For State agency, enter 4-digit Letter of Credit number. For local agency, enter the 3-digit identification number used in

previous year(s) that was assigned by FCS. New local agencies shall obtain the identification number from the State agency. The new local agency 3-digit number should be the next unused consecutive identification number. Enter the number (001 or more) of clinics under each local agency's supervision.

Item 3 - Enter the name, address and 10-digit telephone number for the local Agency. For the name and address, enter on letter or number in each block. Abbreviations are permitted, where necessary. This will be used as input information for the CSFP Local Agency Directory.

Item 5a thru 5e - Data should reflect the ACTUAL number of head of household participants by Racial/Ethnic Category who received commodity supplemental foods during the month of April.

Item 5f - Add columns a through e.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0584-0025. The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

FORM FCS-191 (9-95) *Previous editions are obsolete
Electronic Form Version Designed in JetForm 5.01 version*