APPLICATION - SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP) rev 4 11/2024

INSTRUCTIONS: 1. *Fill out all blocks. This application will be returned to you without processing if any information is missing. If an item does not apply, put "NA" in that block.*
2. *Type or clearly print all information. Complete both sides of this form.*

APPLICANT INFORMATION

Government ID # *(driver's license state ID, Medicare ID, etc.)* _____

County: _____

First Name: _____ Last Name: _____

Address *(number & street)*: _____ Apartment: _____

City: _____ State: _____ ZIP Code: _____

Telephone Number: (_____) _____ - _____ Date of Birth: _____ / _____ / _____
Smart Phone? ☐ Yes ☐ No *mm/dd/yyyy*

Operating System: ☐ iOS ☐ Android

Email Address: _____

Gender: ☐ Male ☐ Female ☐ Non-binary/nonconforming

The collection of gender, race, and ethnicity is requested solely for the purpose of determining the state agency's compliance with Federal civil rights laws and ensures that the program is administered in a non-discriminatory manner. Your responses to these questions will not affect consideration of your application. If you choose not to self-identify gender, race, and ethnicity, then the person taking the application must record the participant's race and ethnicity based on visual observation. (7 CFR 249.7(a)(vi)).

ETHNICITY CATEGORY

☐ Hispanic or Latino
☐ Not Hispanic or Latino

RACE CATEGORY *(select one or more)*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian / Pacific Islander
☐ White

To be eligible to receive Senior Farmers' Market Nutrition Program (SFMNP) checks, you must be at least sixty (60) years of age (or a person with disabilities, under age sixty (60), currently living in a housing facility occupied primarily by older persons where congregate nutrition services are provided); meet the income guidelines, which are based on 185% of the Federal Poverty Income Guidelines; and live within the service area of the administering local agency.

CATEGORICAL ELIGIBILITY

Do you or a household member currently receive benefits from any of the following programs?

☐ SNAP (Food Stamps) ☐ TANF ☐ CSFP ☐ WIC

Monthly Income: _____ Number in Household: _____
(from all sources; before taxes or deductions, for all household members)

PROXY

A proxy is a person you authorize to receive and/or redeem SFMNP checks on your behalf. A proxy must be at least eighteen (18) years of age and should be dependable for the duration of the program season. In order for the checks to be issued to a proxy, the proxy must present identification as well as written approval from the participant. Proxies have the same obligations to follow program guidelines when purchasing fruits and vegetables from an authorized farmer.

I authorize the following individual(*s*) to act as my proxy.

Proxy 1: _____ _____
Last Name *First Name*

Proxy 2: _____ _____
Last Name *First Name*

☐ Check here if no proxy is authorized.

APPLICANT ATTESTATION

I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility is correct to the best of my knowledge. I am aware that I cannot receive SFMNP benefits from more than one state or more than one local agency. This application is submitted in connection with a federal benefit. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the state agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under state and federal law.
I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP program.
I attest that household size and income listed on this application are accurate.

_____ Date: _____/_____/_____
Signature of Applicant *mm/dd/yyyy*

CIVIL RIGHTS / NONDISCRIMINATION

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/ sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

Applicant – Do not write below this line. Area below is for local agency use only.

ELIGIBILITY DETERMINATION

Date **properly completed** application was received by the local agency : _____ / _____ / _____
mm/dd/yyyy

Is applicant eligible? Yes ☐
No ☐ Denial document provided to client: _____ / _____ / _____
mm/dd/yyyy

_____ Date Signed: _____ / _____ / _____
Signature of Staff/Volunteer *mm/dd/yyyy*