# APPLICATION - SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP)

State Form 53250 (R6 / 1-21)
Indiana State Department of Health

*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

ID# _____

County: _____

First Name: _____ Last Name: _____

Address *(number and street)*: _____ Apartment Number: _____

City: _____ State: _____ ZIP code: _____

Telephone Number: (_____) _____-_____ Date of Birth: _____/_____/_____
*mm/dd/yyyy*

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 ☐ CFSP ☐ 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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) fax: (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.***

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## ELIGIBILITY DETERMINATION

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

Is applicant eligible for SFMNP benefit? ☐ Yes ☐ No

Issued SFMNP Check numbers: ☐ Yes, numbers _____ through _____

☐ No, denial provided to client: Date: ___/___/_____
*mm/dd/yyyy*

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