Distribution Site	County

Iowa Department of Agriculture and Land Stewardship
Senior Farmers Market Nutrition Program (SFMNP)
2021 Application

*****Please Complete & Return to Your Local Area Agency on Aging*****

You must be 60 years of age and meet the income guidelines to complete this application.
Only one form needed for married couples.

Do you qualify? Three of the four boxes below must be checked to qualify.

- ❑ I am 60 years of age or older at the time of this application (born in or before 1961)
- ❑ I live in the service area of this Area Agency on Aging
- ❑ For single person: My yearly income is equal to or less than $23,828
- ❑ For a married couple: Our yearly income is equal to or less than $32,227

APPLICANT INFORMATION

Each qualified senior will receive only one checkbook of SFMNP benefits per season.

Last Name (PRINT)	**First Name**	**Date of Birth** ____/____/____	**Last four digits of Social Security #**	**Check Numbers Issued** (office use only)
Hispanic/Latino ❑ **Yes** ❑ **No**		**Race (Select one or more)** ❑ **White** ❑ **American Indian or Alaskan Native** ❑ **Black** ❑ **Native Hawaiian or Other Pacific Islander** ❑ **Asian**		

If living: Spouse's Last Name (PRINT)	**First Name**	**Date of Birth** ____/____/____	**Last four digits of Social Security #**	**Check Numbers Issued** (office use only)
Hispanic/Latino ❑ **Yes** ❑ **No**		**Race (Select one or more)** ❑ **White** ❑ **American Indian or Alaskan Native** ❑ **Black** ❑ **Native Hawaiian or Other Pacific Islander** ❑ **Asian**		

Street Address:	**Apt. #**	**Telephone #**
City	**State**	**Zip Code**

PROXY INFORMATION **(optional: you may select a proxy if you wish, see reverse side for more information; please note, you do not need to be a proxy for your spouse: if needed, you may sign this application at the bottom for yourself and your spouse)**

Proxy Last Name	**Proxy First Name**	**Telephone #**	
Street Address	**City**	**State**	**Zip**

(Proxies do not need to sign the 2021 application)

If you have designated a proxy on page one, you agree to the following three statements*:

I understand that a proxy may act on behalf of more than one eligible participant.

I understand that a proxy may pick up and use checks as long as the benefits are ultimately received by the eligible participant.

I (we) authorize the person listed as a proxy on page one of this application to pick up and utilize the checks issued to me (us) to purchase fresh produce on my (our) behalf.

***please note, you do not need to be a proxy for your spouse: if needed, you may sign this application at the bottom for yourself and your spouse**

Please read or have the following information read to you.

I have been advised that obtaining SFMNP benefits from more than one service delivery area is illegal.

I have been advised of my rights and obligations under the SFMNP. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of federal assistance. 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.

Standards for eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex.

I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

_____ _____

Signature of Applicant Date Signature of Spouse, if applicable Date

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USDA Nondiscrimination Statement

FNS nutrition assistance programs, State or local agencies, and their sub recipients, must post the following Nondiscrimination Statement: 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.