

Iowa Senior Farmers Market Nutrition Program (SFMNP) 2023 Application



RETURN COMPLETED APPLICATION TO:

NEI3A
Attn: Farmers Market
3840 W. 9th Street
Waterloo, IA 50702

Read before applying:

Eligible senior applicants may receive **only one set of checks per year**. The set of checks is valued at \$50, and may be used to purchase fresh produce and honey at authorized farmers markets and farmstands. Seniors must submit a complete application each year to receive the checks and may only receive one set of checks per year. Only one application is needed if both spouses meet the age and income eligibility requirements. **Do not list a second applicant (spouse) if they are deceased, or under 60 years of age.**

Age and Income Eligibility Requirements *(check all that apply)*

- Applicant(s) are 60 years of age or older. (Born on or before today's date, 1963)
- Individual applicant's annual income of \$0-\$26,973
- For 2 applicants (ex. spouses) submitting a joint application, annual household income of \$0-\$36,482

Applicant 1		
Last Name <i>(Print legibly)</i>	First Name	Date of Birth ____/____/____ <hr/> Last four digits of Social Security # ____ ____ ____ ____
Are you Hispanic or Latino? <i>(Select only one)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your race? <i>(Select one or more)</i> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	
Checks Issued: <i>Office use only</i>		

Applicant 2		
<i>Second applicant must be 60 years of age or older</i>		
Last Name <i>(Print legibly)</i>	First Name	Date of Birth ____/____/____ <hr/> Last four digits of Social Security # ____ ____ ____ ____
Are you Hispanic or Latino? <i>(Select only one)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your race? <i>(Select one or more)</i> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	
Checks Issued: <i>Office use only</i>		

Applicant(s) Contact Info:		
Mailing Address:	Apt/Unit #	Phone:
City, State, Zip:		County of Residence:

Signature Required on Reverse

Proxy Information (*optional*) A proxy is an individual authorized to act on your behalf by using SFMNP checks on behalf of an eligible senior participant. You do not have to designate your spouse as a proxy. If you designate a proxy, you agree to the following 3 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 below as a proxy to pick up and utilize the checks issued to me (us) to purchase fresh eligible foods on my (our) behalf.

Designated Proxy Name: (<i>Print legibly</i>)	Phone:
Relationship to Applicant:	

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 1	Date	Signature of Applicant 2	Date
		<i>(if applicable)</i>	

USDA Nondiscrimination Statement

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, audiotope, 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/ad-3027.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:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

or **fax:** (833) 256-1665 or (202) 690-7442;
or **email:** Program.Intake@usda.gov

This institution is an equal opportunity provider.