South Carolina Department of Social Services

SENIOR FARMERS' MARKET NUTRITION PROGRAM APPLICATION

I am applying to receive Seniors Farmers' Market Nutrition Program checks that will be used to purchase eligible fresh produce from authorized farmers at participating farmers' markets and or roadside stands. I understand that I may only receive SFMNP benefits once during each operating season and I provide assurance that I have not already applied for, and received SFMNP benefits prior to the submission of this application for the current season.

SFMNP

Racial / Ethnic Data for statistical purposes only; will not affect consideration of request for assistance.

❑ Male ❑ Female	**Racial Category (Check all that apply)**
Hispanic? ❑ Yes ❑ No	❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White

Name: _____ Age: _____ County of Residence: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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 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, 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.

_____ _____

Applicant/Proxy Signature Application Date

This institution is an equal opportunity provider and employer.

ELIGIBILITY DETERMINATION (Completed by Local Agency Staff)

Currently Receives:	HH Income Calculation:	Eligible: ❑ Yes ❑ No If not eligible, give reason for denial below:
❑ SNAP ❑ SSI	Total HH Income: _____ Number in HH: _____ (Refer to Income Chart)	_____ _____ **Local Agency Representative:** _____

IDENTIFICATION NO.		**COUPON ISSUANCE**
		Beginning No.: _____ **Ending No.:** _____

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)