APPLICATION - SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP)
State Form 53250 (R5 / 1-16)
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.

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))

County _____ Date of Application: _____/_____/_____
mm/dd/yyyy

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

Address: _____ _____ _____ _____
Street *City* *State/ZIP code* *Telephone Number*

Date of Birth: _____/_____/_____ Number in Household: _____ Gender: ☐ M ☐ F
mm/dd/yyyy

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 or Other Pacific Islander
☐ White
☐ Multi-Racial *(Please specify above.)*

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 in the county where the checks are being issued.

CURRENT PARTICIPANT Are you a current participant of the following?

☐ SNAP (Food Stamps)
☐ TANF
☐ CFSP
☐ Member of a WIC Household

Monthly Income: _____ Income eligible for the above programs? ☐ Yes ☐ No

Is applicant eligible for SFMNP? ☐ Yes ☐ No Given SFMNP Checks? ☐ Yes ☐ No

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

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

PROXY

A proxy is a person only authorized to receive and/or redeem SFMNP checks. A proxy should be at least eighteen (18) years of age and dependable for the duration of the program months of operation. 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 must sign the check register to receive checks. 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.
Participant signature

Assigned proxies:

Proxy 1: _____ _____
Last Name *First Name*

Proxy 2: _____ _____
Last Name *First Name*

☐ **Check here if no proxy was assigned.**

CERTIFICATION BY PARTICIPANT

I have been advised of my rights and obligations for use of SFMNP Checks. 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 Farmers' Market benefits from more than one state or more than one local agency. This application 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 Indiana SFMNP program 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 program.

I certify that I meet the household size and income guidelines provided by the state and that I am eligible to receive SFMNP benefits.

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

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

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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.
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