



# 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

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.



**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](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](mailto: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

\_\_\_\_\_  
Signature of Staff/Volunteer

Date Signed:     /    /      
mm/dd/yyyy