Please read this application
and the accompanying information sheet
and print or type clearly.

For Official Use Only:

Coupon #_____ - _____

2017 Senior Farmers' Market Nutrition Program (SFMNP)
Application Form

Please print clearly and mail completed application to:

Department of Labor and Industrial Relations
Office of Community Services
830 Punchbowl Street, Room 420
Honolulu, Hawaii 96813

The Seniors Farmers Market Nutrition Program (SFMNP) provides low-income seniors with eligible fresh produce with the goal of improving their health and nutritional status. An application must be completed for each person in the household that qualifies for SFMNP benefits. **Applicants must be certified to participate each year.** The number of participants is limited. First come, first served.

I attest that I meet the following eligibility criteria (please check all that apply):

☐ I have not applied for Senior Farmers' Market benefits in 2017.

- Categorical Eligibility Requirement:
  - ☐ I am at least 60 years of age.
  - ☐ I am a Native American at least 55 years of age.
  - ☐ I am a disabled individual less than 60 years old and living in a senior housing facility.
- Maximum Annual Household Income Eligibility Requirement:
  - ☐ My household income is less than 185% of the U.S. Poverty Rate for Hawaii:
    - Less than $25,290, for a one person household
    - Less than $34,096 for a two person household
    - For each additional person, add $8,806 per additional household member (including children)
- Residency Eligibility Requirement:
  - ☐ I am a resident of the county in which I am applying for service.

	In what county are you applying for service? ☐ **Hawaii Island** ☐ **Honolulu/Oahu** ☐ **Kauai** ☐ **Maui**	
Name (Last, First, M.I.)	**Gender**	**Date of Birth (MM/DD/YYYY)**
Residential Address (including unit #)		**City, Zip Code**
Mailing Address (including unit #) if different from Residential Address		**City, Zip Code**
Telephone Number **( )**	**Email Address**	

ETHNIC BACKROUND

USDA requires the State to obtain race and ethnic information. This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.

Please check one:	**Please check all that apply:**	
Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No	☐ Native American or Alaskan Native ☐ African American ☐ Native Hawaiian or Other Pacific Islander	☐ Asian ☐ Caucasian ☐ Other

PROXY

A "proxy" or "authorized representative" is defined as an individual authorized by an eligible participant to act on the participant's behalf, including submission of application for certification, receipt of SFMNP coupons or other benefits, or use of SFMNP coupons at authorized outlets as long as the SFMNP benefits are ultimately received by the eligible senior.

I hereby authorize the following individual to act as my authorized representative for the SFMNP to submit my application for certification, receive my SFMNP coupons or other benefits, or shop at a farmers' market on my behalf.

Proxy Name (Last, First, M.I)	**Relationship**	**Proxy Phone Number** **( )**

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.

By signing this form, I certify that I meet all three of the categorical, income, and residency eligibility requirements; have and will not apply for SFMNP benefits in another county service area, acknowledging it is illegal to partake in dual participation; and acknowledge that I have been given SFMNP Rights and Responsibility information.

_____ _____

Applicant Signature **Date (MM/DD/YYYY)**

This institution is an equal opportunity provider.

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