2024 Senior Farmers' Market Nutrition Program

IMPORTANT: This program is seasonal (**April 1 to October 31**) and it is very popular. Spaces are extremely limited. Submit you application ASAP. Most counties' spaces fill up by May or June. Late applicants will be wait-listed.
Please mail your completed application to: 99 Mahalani St., Wailuku, HI 96793

Name (Last, First, M.I.) *PRINT YOUR NAME CLEARLY!*	**( ) Male** **( ) Female**	**Date of Birth (MM/DD/YYYY)**

I certify that all of the following statements are true and correct:

1. I am at least 60 years of age.
2. I reside in the county where I am requesting to receive food coupons.
3. I am making only one request for ten SFMNP food coupons for the 2024 program year.
4. I meet the total maximum annual household income requirement stated here: $32,024 – 1 person, $43,475 – 2 persons, add $11,452 additional household member (including children).

Number of persons in household	**Annual Household Income** **$**
Mailing Address (include apartment or unit number) – *WRITE CLEARLY!*	**City, Zip Code**
Email Address	**Telephone Number** **( )**

DESIGNATION OF PROXY (Optional)

A "Proxy" or "authorized representative" is someone authorized by an eligible participant to act on the participant's behalf, including submission of application for participation, receipt of coupons, and use of SFMNP coupons at authorized outlets as long as the SFMNP benefits are ultimately received by the eligible senior. **If you want your coupons mailed to your proxy instead of yourself, insert proxy's contact information here:**

Proxy Name (Last, First, M.I.)	**Relationship**	**Proxy Phone Number** **( )**
Mailing Address (include apartment or unit number) – *WRITE CLEARLY!*		**City, Zip Code**

ETHNIC GACKGROUND

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

Do you consider yourself Hispanic or Latino? Please check one: **( ) Yes ( ) No**	**Please check all that apply:** **( ) American Indian or Alaskan Native ( ) Asian ( ) White** **( ) Black or African American ( ) Native Hawaiian or other Pacific Islander**

Certification Statement

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 my 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 low. Standards of eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

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

This institution is an equal opportunity provider.

Form OCS-SFMNP-1 rev. Feb 2024

Entered _____ Eligible YES NO Approved_____

For Official Use Only:

Coupon #: _____ - _____