Each eligible applicant must complete a separate application.

LIFECARE ALLIANCE	**2019 Ohio Senior Farmers' Market Nutrition Program**	**670 Harmon Avenue Columbus, OH 43223 (614)278-3130**

First Name	**Middle Initial**	**Last Name**	
Date of Birth: (mm/dd/yy)		**Age:**	**Sex:** ☐ Male ☐ Female
Mailing Address			**Apt #**
City		***State***	**ZIP Code**
E-mail Address (Optional):			
Please circle the county, where you live. Fairfield – Fayette – Franklin – Licking Madison – Pickaway - Union		**Telephone Number:** ( )	

Ethnicity: (select one)	**Race:** (select one or more; information collected for federal statistics)
☐ Not Hispanic/Latino ☐ Hispanic/Latino	☐ American Indian/Alaskan Native ☐ African-American/Non-Hispanic ☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ White

Please complete the following **ONLY** if you are shopping on behalf of the above applicant such as a caregiver:

Personal Shopper/Proxy Name (if applicable):	**Relationship to Participant:**	**Contact Number:** ( )
State ID or Driver's License Number:	**Personal Shopper / Proxy Signature:**	

*(Check box corresponding to your **TOTAL** household income)*

☐ **1** person in household income of **$0 - $23,107**	☐ **2** persons in household with income of **$0 - $31,284**	☐ **3** persons in household with income of **$0 - $39,461**
☐ **4** persons in household with income of **$0 - $47,638**	☐ 5 persons in household with income of **$0 - $55,815**	☐ **6** persons in household with income of **$0 - $63,992**

I certify that I am at least 60 years of age; a resident of this service area; have not received coupons at any other location; and total household income requirements are met.

Applicant's Signature:_____ Date: _____

I have been advised of my rights and obligations under the SFMNP. I certify the information I have provided is correct. This form is being submitted for Federal Assistance and is subject to verification. I understand that 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. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. Information will not be shared except for the specific purposes of responding to your request for assistance.

USDA prohibits discrimination on the basis of race, color, national origin, gender, age, or disability.