

Each eligible applicant must complete a separate application, and each applicant must be 60 as of 7/1/2020.

		2020 Ohio Senior Farmers' Market Nutrition Program	670 Harmon Avenue Columbus, OH 43223 614-437-2865
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First Name	Middle Initial	Last Name
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Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home Address (This is where we will deliver your produce box, if you are accepted into the 2020 program.)
 Apt #

City	State	ZIP Code
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E-mail Address: (If you have an email address that you use, please provide it so that we may easily communicate with you.):

Please circle the county, where you live. Fairfield – Fayette – Franklin – Licking – Madison – Pickaway – Union	Telephone Number: (Please provide your cell phone number, if you have one that you use.) ()
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Ethnicity (select one) <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	Race (select one or more; information collected for federal statistics) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> African-American/Non-Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian
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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: ()
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State ID or Driver's License Number:	Personal Shopper / Proxy Signature:
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*(Check box corresponding to your **TOTAL** household income)*

<input type="checkbox"/> 1 person in household with income of \$0 - \$23,107	<input type="checkbox"/> 2 persons in household with income of \$0 - \$31,284	<input type="checkbox"/> 3 persons in household with income of \$0 - \$39,461
<input type="checkbox"/> 4 persons in household with income of \$0 - \$47,683	<input type="checkbox"/> 5 persons in household with income of \$0 - \$55,815	<input type="checkbox"/> 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.

<p data-bbox="74 1873 1567 2066">IMPORTANT: Please indicate if you would prefer a mid-summer or a late-summer produce box to be delivered to you. LifeCare Alliance and COAAA cannot guarantee that this is what you will receive, but we will do our best to accommodate your request.</p> <p data-bbox="74 2026 1567 2066">____ Mid-Summer ____ Late-Summer</p>

USDA Nondiscrimination Statement

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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.

This institution is an equal opportunity provider.