Please select one: ■ I'd like to receive $50-worth of farmers' market coupons.
■ I'd like to have a produce box valued at $50 delivered to me.

SENIOR FARMERS' MARKET Nutrition Program

2022 APPLICATION

Ohio Department of Aging

COAAA Central Ohio Area Agency on Aging | LifeCare Alliance | Franklin County Board of Commissioners Office on Aging

RETURN COMPLETED APPLICATION TO:

LifeCare Alliance SFMNP
670 Harmon Ave.
Columbus, OH 43223 1-614-437-2865

Each applicant must complete and submit a separate application for each program year.

First Name		Middle Initial		Last Name	
Birth Date (mm/dd/yyyy) *Must be at least 60 years old to participate*		Gender	☐ Male	☐ Female	☐ No Answer
Mailing Address					
City		Zip Code		County	
Telephone Number					
Email Address					

Race (select all that apply)

☐ American Indian/Native Alaskan	☐ Black/African American	☐ White, Non-Hispanic
☐ Asian	☐ Native Hawaiian/Other Pacific Islander	☐ White, Hispanic

Nationality (select all that apply)

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	

Complete the following information ONLY if applicant is designating an authorized shopper.

Authorized Shopper Name			
Relationship to Participant		Telephone Number	

Check box corresponding to your TOTAL annual household income and household size.

☐	1 person in household with income of $0-$25,142	☐	2 persons in household with income of $0-$33,874	☐	3 persons in household with income of $0-$42,606
☐	4 persons in household with income of $0-$51,338	☐	5 persons in household with income of $0-$60,070	☐	6 persons in household with income of $0-$68,802

I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Famers' Market Nutrition Program 2022 coupons at any other location; and have a total household income that meets income requirements.

Applicant Signature		Date	

I have been advised of my rights and obligations under the Ohio Senior Farmers' Market Nutrition Program (SFMNP). I certify the 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.