2021 Senior Farmer's Market Nutrition Program

IMPORTANT: This program is seasonal- **APRIL 1- OCTOBER 31ST 2021**, and it is very popular, Spaces are extremely limited. Submit your application ASAP. Most counties' spaces fill up by March or June. Late applicants will be wait-listed. **Please mail your completed application to: HCEOC- SFMNP, 47 RAINBOW DR., HILO, HI 96720**

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 2020 program year.
4. I meet the total household income requirement stated below.

1-person household income of less than $26,603	2-person household income of less than $36,001	For each additional person, add $9,398 per additional household member (including children)
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 address here:______________________, Hawaii ______

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

ETHNIC BACKGROUND

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.

Please check one: Do you consider yourself Hispanic or Latino? ( ) Yes ( ) No	Please check all that apply: ( ) American Indian or Alaskan Native ( ) Asian ( ) Black or African American ( ) White ( ) 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 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 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/YY)

This institution is an equal opportunity provider

Form OCS-SFMNP-1 rev. Jan 2020
For Official Use Only:
Coupon # _____ _______