

# Virginia Senior Farmers Market Nutrition Program (SFMNP) Application

Please Print

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

| <b>Applicant</b>   |  | <b>Second Applicant - Same Household Unit</b>   |  |
|--|--|---|--|
| Name:  |  | Name:   |  |
| (Last)   | (First)  | (MI)  | (Last)   |
|  |  | (First)   |  |
|  |  | (MI)  |  |
| <b>Residence Address:</b>                                |  |   |  |
| (Street)   |  |   |  |
| (City)   |  | (State) (Zip)                                   |  |
| (County)   |  |   |  |
| Address to which checks are to be mailed (if different): |  |   |  |
| (Street/P.O. Box)  |  |   |  |
| (City)   |  | (State) (Zip)                                   |  |
| ( )  |  |   |  |
| Phone  |  |   |  |
| Birthdate: ____ / ____ / ____                            |  | Birthdate: ____ / ____ / ____                   |  |
| (Month) (Day) (Year)                                     |  | (Month) (Day) (Year)                            |  |
| <b>Applicant Demographics</b>                            |  | <b>Second Applicant Demographics</b>            |  |
| <b>Ethnicity:</b> Mark one, regardless of Race           | <b>Race:</b> Mark one or more                                | <b>Ethnicity:</b> Mark one, regardless of Race  | <b>Race:</b> Mark one or more                                |
| <input type="checkbox"/> Hispanic or Latino              | <input type="checkbox"/> American Indian or Alaskan Native   | <input type="checkbox"/> Hispanic or Latino     | <input type="checkbox"/> American Indian or Alaskan Native   |
| <input type="checkbox"/> Not Hispanic or Latino          | <input type="checkbox"/> Asian                               | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian                               |
|  | <input type="checkbox"/> Black or African American           |   | <input type="checkbox"/> Black or African American           |
|  | <input type="checkbox"/> Native Hawaiian or Pacific Islander |   | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
|  | <input type="checkbox"/> White                               |   | <input type="checkbox"/> White                               |
| <b>Office Use Only</b>                                   |  |   |  |
| <b>Check Numbers Issued</b>                              |  |   |  |
| _____  |  | _____   |  |
| Staff Initials   |  | Date  |  |

## Self-Declaration for Income Eligibility

Number of People in Household \_\_\_\_\_

Total Monthly Household Income \_\_\_\_\_

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## Certification - By my signature below I certify that

I understand that it is unlawful to receive farmer's market checks from more than one locality or to enroll in this program more than one time each Market Season. 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 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 my repaying the Virginia Department for the Aging, 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. I understand the Program's household income eligibility guidelines or have had them explained to me. I hereby acknowledge with my signature that my household family income is within the published income eligibility guidelines for participation in SFMNP.

|                               |             |                                      |             |
|-------------------------------|-------------|--------------------------------------|-------------|
|                               |             |                                      |             |
| <b>Signature of Applicant</b> | <b>Date</b> | <b>Signature of Second Applicant</b> | <b>Date</b> |

## Return Completed Applications To This Address:

Central Virginia Alliance for Community Living  
Farm Market Fresh Program  
50112<sup>th</sup> Street  
Lynchburg, Va  
24504

or

Fax to: 434-385-9209

# Virginia Senior Farmers Market Nutrition Program (SFMNP) A p p l i c a t i o n

**USDA Non-Discrimination Statement – DO NOT mail completed applications to the address below. The address below is to file a program complaint of discrimination.**

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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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto:program.intake@usda.gov).

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