



Farm Market Fresh

Senior & WIC Farmers' Market Nutrition Program (S/FMNP)

2024 Senior Application

Please Print

Today's Date: ____ / ____ / ____

Applicant #1

Name: _____
Last, First MI

Birthdate: ____ / ____ / ____
(Month) (Day) (Year)

Applicant #2 - Same Household Unit (Optional)

Name: _____
Last, First MI

Birthdate: ____ / ____ / ____
(Month) (Day) (Year)

Address of Residence: _____
Street

City State Zip County
 Mailing Address is same as Residence

Mailing Address: _____
Street

City State Zip County

Email (optional): _____

Home Phone: _____ Cell Phone: _____

Applicant #1 Demographics		Applicant #2 Demographics	
Ethnicity: Mark one, regardless of Race	Race: Mark one or more	Ethnicity: Mark one, regardless of Race	Race: Mark one or more
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer

Office Use Only:		
Voucher Numbers Issued: _____	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 S/FMNP. 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 S/FMNP. 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 S/FMNP.

Signature of Applicant #1: _____ **Date:** _____

Signature of Applicant #2: _____ **Date:** _____

Return Completed Applications To This Address or Email:

Central Virginia Alliance for Community Living, Inc.

501 12th Street, Suite A

P. O. Box 1390

Lynchburg, VA 24505

jrobey@cvcl.org



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USDA Non-Discrimination Statement

DO NOT mail completed applications to the address below. The address below is to file a program complaint of discrimination.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email:

Program.Intake@usda.gov

This institution is an equal opportunity provider.