NEW JERSEY DEPARTMENT OF HEALTH

SENIOR FARMER'S MARKET NUTRITION PROGRAM (SFMNP)

APPLICATION FOR ELIGIBILITY

Senior Local Agency: _____ Application Date:_____

Distribution Site: _____

FAMILY INFORMATION SCREEN

AUTHORIZED REPRESENTATIVE (Head of Household)

Last Name: _____ First Name:_____ MI:_____

Date of Birth: _____Gender:_____

Primary Language:_____ E-mail:_____

ALTERNATE AUTHORIZED REPRESENTATIVE (Formerly "Proxy")

Last Name: _____ First Name:_____ MI:_____

Date of Birth: _____Gender:_____

Primary Language:_____ E-mail:_____

STREET ADDRESS (Household):

_____

City: _____ County: _____ Zip Code:_____

☐ Mailing Address Different from Street Address:

MAILING ADDRESS:

_____

City: _____ County: _____ Zip Code:_____

Phone Number: _____ Family Size: _____

** If Homeless, please provide at least 1 form of Identity **

☐ Driver License ☐ Birth Certificate ☐ Social Security Benefits Statement

Other: _____

PARTICIPANT REGISTRATION SCREENS

NOTE: Authorized Representative may also be a Participant; Maximum of 2 Participants per family.

Participant #1

Last Name: _____ First Name:_____ MI:_____

Date of Birth: _____Gender:_____PrimaryLanguage:_____

Martial Status:_____Phone Number: _____

ETHNICITY:

- ☐ Hispanic
- ☐ Non-Hispanic

RACE: Check all that apply

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

PROOF OF IDENTITY

- ☐ Birth Certificate
- ☐ Driver's License
- ☐ Immigration Documents
- ☐ Medical Card or Records
- ☐ Other (Specify):_____

Participant #2

Last Name: _____ First Name:_____ MI:_____

Date of Birth:_____Gender:_____PrimaryLanguage:_____

Martial Status:_____Phone Number: _____

ETHNICITY:

- ☐ Hispanic
- ☐ Non-Hispanic

RACE: Check all that apply

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

PROOF OF IDENTITY

- ☐ Birth Certificate
- ☐ Driver's License
- ☐ Immigration Documents
- ☐ Medical Card or Records
- ☐ Other (Specify):_____

Participant #1: INCOME INFORMATION

Do you receive any of the following?

☐ CSFP ☐ SNAP (Food Stamp) ☐ SSI ☐ Medicaid

Income Source:

- ☐ Affidavit – Self Declaration
- ☐ Bank Statement
- ☐ SSI/Disability Letter
- ☐ Employers Letter
- ☐ Medicaid Verification
- ☐ Recent Pay Stub
- ☐ Reliable 3rd Party Letter
- ☐ Social Security/Retirement Statement
- ☐ SNAP Verification
- ☐ Unemployment Benefits
- ☐ W-2, prior year

Monthly Income: _____

Participant #2: INCOME INFORMATION

Do you receive any of the following?

☐ CSFP ☐ SNAP (Food Stamp) ☐ SSI ☐ Medicaid

Income Source:

☐ Affidavit – Self Declaration
☐ Bank Statement
☐ SSI/Disability Letter
☐ Employers Letter
☐ Medicaid Verification
☐ Recent Pay Stub
☐ Reliable 3rd Party Letter
☐ Social Security/Retirement Statement
☐ SNAP Verification
☐ Unemployment Benefits
☐ W-2, prior year

Monthly Income: _____

SFMNP: RIGHTS AND OBLIGATIONS

1. I understand that I can receive SFMNP benefits from only (1) County or Municipal Office on Aging at a time.
2. I certify that I am not and will not attempt to enroll or obtain benefits from another County or Municipal Office on Aging.
3. I understand the SFMNP Eligibility Criteria, and I certify that all of the information that I have provided in this application is true and accurate.
4. I understand that the State, County or Municipality has the right to verify my information.
5. I understand that I can be disqualified from the SFMNP for failure to comply with these Rights and Obligations, and that this may result in penalties or in disqualification from the SFMNP for the next year.
6. The County or Municipal Office on Aging will make health and nutrition services available to me, and I am encouraged to participate in these services.

By my signature, I certify that I have been advised of the Rights and Obligations and the Eligibility Criteria for the Senior Farmers Market Nutrition Program, and the information I have provided here is true and accurate.

_____ _____
Signature of Participant #1/ Authorized Representative Date

_____ _____
Signature of Participant #2 Date

APPROVED: **DENIED:**

_____ _____
Signature of Local Agency Staff Date

USDA Nondiscrimination Statement

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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.