



**Appalachian Agency for Senior Citizens
Virginia Senior Farmers Market Nutrition Program
(SFMNP) Application-2019**

PLEASE PRINT

Today's Date: ____ / ____ / ____

Applicant		Second Applicant - Same Household Unit	
Name: _____ <small>(Last) (First) (MI)</small>		Name: _____ <small>(Last) (First) (MI)</small>	
APPLICANT: (Must be 60 years old or older) Birth date: ____ / ____ / ____ <small>(Month) (Day) (Year)</small>		SECOND APPLICANT: (Must be 60 years old or older) Birth date: ____ / ____ / ____ <small>(Month) (Day) (Year)</small>	
Residence Address: _____ <small>(PO Box/ Street Address)</small> _____ <small>(City) (State) (Zip)</small>			
Address to which checks are to be mailed (if different than above): _____ <small>(PO Box/ Street Address)</small> _____ <small>(City) (State) (Zip)</small>			
County of Residence: <i>(check one)</i> <input type="checkbox"/> Buchanan <input type="checkbox"/> Dickenson <input type="checkbox"/> Russell <input type="checkbox"/> Tazewell		PHONE: () _____	
Applicant Demographics		Second Applicant Demographics	
Ethnicity: Mark one, regardless of Race <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> NOT Hispanic or Latino Origin	Race: Mark one or more <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White or Caucasian	Ethnicity: Mark one, regardless of Race <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> NOT Hispanic or Latino Origin	Race: Mark one or more <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White or Caucasian

Self Declaration for Income Eligibility

Number of People in Household: _____

Total Monthly Household Income: _____

Office Use Only: Staff Initials _____ Date _____ Check Numbers Issued _____
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CONTINUED ON BACK

Certification - By my signature below I certify that

I understand that it is unlawful to receive farmer’s market coupons 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. Standards for eligibility and participation in the Senior Farmer’s Market Nutrition Program are the same for everyone, regardless of race, color, national origin, age, disability, or sex.

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.

X:		X:	
Signature of Applicant	Date	Signature of Second Applicant	Date

Return Completed Application To This Address:

**Appalachian Agency for Senior Citizens
Attn: SFMNP
PO Box 765
Cedar Bluff, VA 24609**