



Appalachian Agency for Senior Citizens
Farm Market Fresh for Older Adults

Virginia's Senior Farmers Market Nutrition Program (SFMNP)

Application- 2023

Today's Date: _____ / _____ / _____

Applicant <i><u>PLEASE PRINT</u></i>		Second Applicant - Same Household Unit	
Name: _____		Name: _____	
(Last) (First) (MI)		(Last) (First) (MI)	
APPLICANT: (Must be 60 years old or older)		SECOND APPLICANT: (Must be 60 years old or older)	
Birth date: _____ / _____ / _____		Birth date: _____ / _____ / _____	
(Month) (Day) (Year)		(Month) (Day) (Year)	
Residence Address:			
(PO Box/ Street Address)			

(City) (State) (Zip)			
Address to which checks are to be mailed (if different than above):			
(PO Box/ Street Address)			

(City) (State) (Zip)			
County of Residence: (check one)		PHONE: () _____	
<input type="checkbox"/> Buchanan <input type="checkbox"/> Dickenson <input type="checkbox"/> Russell <input type="checkbox"/> Tazewell			
Applicant Demographics		Second Applicant 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 Origin <input type="checkbox"/> NOT Hispanic or Latino Origin	<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	<input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> NOT Hispanic or Latino Origin	<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 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.

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**

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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, audiotope, 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.