NEW JERSEY DEPARTMENT OF HEALTH

SENIOR FARMER'S MARKET NUTRITION PROGRAM (SFMNP)

APPLICATION FOR ELIGIBILITY

Senior Local Agency: **Warren County** 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: __________

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

☐ Driver License ☐ Birth Certificate ☐ Social Security Benefits Statement

Other: ____

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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:__________________

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:__________________

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 (Gross Income Only)
☐ 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.

SFMNP INCOME ELIGIBILITY GUIDELINES

Participation in the Senior Farmers' Market Nutrition Program is limited to those senior citizens who are 60 years and older and whose **Household Income** is equal to or less than the income poverty guidelines below.

WIC Income Eligibility Guidelines (Effective from June 1, 2023, to June 30, 2024)					
48 Contiguous States, D.C., Guam and Territories					
Family Size	**Annual**	**Monthly**	**Twice-Monthly**	**Bi-Weekly**	**Weekly**
1	$26,973	$2,248	$1,124	$1,038	$519
2	$36,482	$3,041	$1,521	$1,404	$702
3	$45,991	$3,833	$1,917	$1,769	$885
4	$55,500	$4,625	$2,313	$2,135	$1,068
5	$65,009	$5,418	$2,709	$2,501	$1,251
6	$74,518	$6,210	$3,105	$2,867	$1,434
7	$84,027	$7,003	$3,502	$3,232	$1,616
8	$93,536	$7,795	$3,898	$3,598	$1,799
Each Add'l Member Add	+ $9,509	+ $793	+ $397	+ $366	+ $183

My signature indicates that I have reviewed the income guidelines by household. By signing this I attest that my income is at or below my household size, listed above. I also affirm that I live in **Choose One:** ____________ County, and I am at least 60 years of age. I understand that if any of these statements are found to be fraudulent, I will be subjected to sanctions per the State Policy and Procedures.

1. Name of Participant (Print) | 1. Signature | Date

2. Name of Participant (Print) | 2. Signature | Date

3. Alternate Authorized Representative (Print) | 3. Signature | Date

NEW JERSEY DEPARTMENT OF HEALTH
SENIOR FARMERS MARKET NUTRITION PROGRAM (SFMNP)

Alternate Authorized Representative Form

- You can give permission to another person to act on behalf of you and your family with the Senior Farmers Market Nutrition Program.
- This person is called an **Alternate Authorized Representative.** (In the past we called this person a "Proxy".)

You will need to give signed permission to your Alternate Authorize Representative and they will need to agree to follow the Rights and Obligations of the SFMNP.

SFMNP Authorized Representative Statement

I, ____, DOB ____________________________
Name of Authorized Representative/Participant

designate, ____ to act on behalf of myself and
Name of Alternate Authorized Representative
my family in matters concerning my enrollment and benefits of the Senior Farmers Market Program.

____ ______________________
Signature of Authorized Representative Date

SFMNP Alternate Authorized Representative Statement

I agree to act on behalf of ____ and will comply with all the rules and policies of the Senior Farmers Market Program. I understand that I must present a valid form of identification at the Senior Local Agency.

____ ______________________
Signature of Alternate Authorized Representative Date