



**2017
Ohio Senior Farmers'
Market Nutrition Program**

1400 Pike Street
Marietta, OH 45750
1-800-331-2644

First Name:		Middle Initial:	Last Name:	
Date of Birth: (mm/dd/yy)			Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address: (include apartment number if applicable)				
City:		State:	ZIP Code:	
e-mail Address (Optional):				
Please circle the county, where you live. Athens, Hocking, Meigs, Monroe, Morgan, Noble, Perry or Washington			Telephone Number: ()	
Have you already received Senior Farmers' Market coupons this year? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, where/how did you obtain these coupons? <input type="checkbox"/> Distribution Site <input type="checkbox"/> Mail	
Ethnicity: (select one) <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino		Race: (select one or more; information collected for federal statistics) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> African-American/Non Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian		
Personal Shopper/Proxy Name (if applicable):		Relationship to Participant:	Contact Number: ()	
State ID or Driver's License Number:			Personal Shopper / Proxy Signature:	

I certify that I am at least 60 years of age; a resident of this service area; have not received coupons at any other location; & total household income requirements are met.

*(Check box corresponding to your **TOTAL** household income)*

<input type="checkbox"/> 1 person in household with income of \$0 - \$22,311	<input type="checkbox"/> 2 persons in household with income of \$0 - \$30,044	<input type="checkbox"/> 3 persons in household with income of \$0 - \$37,777
<input type="checkbox"/> 4 persons in household with income of \$0 - \$45,510	<input type="checkbox"/> 5 persons in household with income of \$0 - \$53,243	<input type="checkbox"/> 6 persons in household with income of \$0 - \$60,976

Applicant's Signature: _____ Date: _____

I have been advised of my rights and obligations under the SFMNP. I certify the information I have provided is correct. This form is being submitted for Federal Assistance, and is subject to verification. I understand that intentionally misrepresenting, concealing or withholding facts may result in paying the State Agency, 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. Information will not be shared except for the specific purposes of responding to your request for assistance.

USDA prohibits discrimination on the basis of race, color, national origin, gender, age, or disability.