

Senior Farmers Market Nutrition Program

## 2024 APPLICATION

regional								<b>RETURN COMPLETED APPLICATION TO:</b> Buckeye Hills Regional Council 1400 Pike Street Marietta, OH 45750 740-374-9436							
Each applicant must complete and submit a separate application for each program year.															
First Name				Middle	Initial	tial Last Na		st Name							
		<b>m/dd/yyyy)</b> t 60 years old to participa	ate						Gender		🗌 Male	🗌 Female	Female No Answer		
Mailing Address															
City				Zip Co		de			County	4					
Telephone Number															
Email Address															
Race (select all that apply)															
<ul> <li>□ American Indian/Native Alaskan</li> <li>□ Asian</li> </ul>				<ul> <li>Black/African America</li> <li>Native Hawaiian/Othe</li> </ul>								White, Non-Hispanic White, Hispanic			
Nationality (select all that apply)															
<ul> <li>Hispanic or Latino</li> <li>Not Hispanic or Latino</li> <li>Unknown</li> </ul>															
Comp	lete th	e following informati	on ONLY	if applic	ant is d	lesign	atir	ng an auth	orized	shop	per.				
Complete the following information ONLY if applicant is designating an authorized shopper.         Authorized Shopper Name															
Relationship to Participant								Telephone Number							
Check box corresponding to your TOTAL annual household income and household size.															
	1 person in household with incom			2 person in hor income of \$0-\$			hοι	usehold with			<b>3</b> person in household with income of <b>\$0-\$47,767</b>				
	4 per	rson in household with income			<b>5</b> person in ho income of <b>\$0-</b>			usehold with			6 perso	6 person in household with income of <b>\$0-\$77,626</b>			
I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Famers' Market Nutrition Program 2024 coupons at any other location; and have a total household income that meets income requirements.															
Applicant Signature									Date						
I have been advised of my rights and obligations under the Ohio Senior Farmers' Market Nutrition Program (SFMNP). I certify the information I have provided is correct. This form is being submitted for Federal Assistance and is subject to vertification. I understand that intentionally misrepresenting, concealing or withholding facts may result in paying the State Agency, in cash, thevalue of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federallaw. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. Informationwill not be shared except for the specific purposes of responding to your request for assistance.															