Each eligible applicant must complete a separate application.

AREA AGENCY on AGING Region 9 AAA9	**2020 Ohio Senior Farmers' Market Nutrition Program**	**710 Wheeling Ave. Cambridge, OH 43725 1-800-945-4250**

First Name	**Middle Initial**	**Last Name**	
Date of Birth: (mm/dd/yy)		**Age:**	**Sex:** ☐ Male ☐ Female
Mailing Address			**Apt #**
City		***State***	**ZIP Code**
E-mail Address (Optional):			
Please circle the county where you live. Belmont – Carroll – Coshocton – Guernsey – Harrison – Holmes – Jefferson – Muskingum – Tuscarawas		**Telephone Number:** ( )	

Ethnicity: (select one)
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

Race: (select one or more; information collected for federal statistics)
- ☐ American Indian/Alaskan Native
- ☐ African-American/Non-Hispanic
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian
- ☐ White

Please complete the following **ONLY** if you are shopping on behalf of the above applicant such as a caregiver:

Personal Shopper/Proxy Name (if applicable):	**Relationship to Participant:**	**Contact Number:** ( )
State ID or Driver's License Number:	**Personal Shopper / Proxy Signature:**	

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

☐ **1** person in household income of **$0 - $23,107**	☐ **2** persons in household with income of **$0 - $31,284**	☐ **3** persons in household with income of **$0 - $39,461**
☐ **4** persons in household with income of **$0 - $47,683**	☐ **5** persons in household with income of **$0 - $55,815**	☐ **6** persons in household with income of **$0 - $63,992**

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; and total household income requirements are met.

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.

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.