# SENIOR FARMERS' MARKET Nutrition Program

# 2022 APPLICATION

Ohio Department of Aging

**Western Reserve** Area Agency on Aging **AAA10A**

**RETURN COMPLETED APPLICATION TO:**

Western Reserve Area Agency on Aging
1700 E. 13th St., Suite 114
Cleveland, OH 44114-3285 216-672-5740

Each applicant must complete and submit a separate application for each program year.

| First Name | | Middle Initial | | Last Name | |
|---|---|---|---|---|---|
| Birth Date (mm/dd/yyyy) *Must be at least 60 years old to participate* | | Gender | ☐ Male | ☐ Female | ☐ No Answer |
| Mailing Address | | | | | |
| City | | Zip Code | | County | |
| Telephone Number | | | | | |
| Email Address | | | | | |

**Race (select all that apply)**

| | | |
|---|---|---|
| ☐ American Indian/Native Alaskan | ☐ Black/African American | ☐ White, Non-Hispanic |
| ☐ Asian | ☐ Native Hawaiian/Other Pacific Islander | ☐ White, Hispanic |

**Nationality (select all that apply)**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

**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 income of $0-$25,142 | ☐ | 2 persons in household with income of $0-$33,874 | ☐ | 3 persons in household with income of $0-$42,606 |
| ☐ | 4 persons in household with income of $0-$51,338 | ☐ | 5 persons in household with income of $0-$60,070 | ☐ | 6 persons in household with income of $0-$68,802 |

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 2022 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 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.