English

NEW JERSEY DEPARTMENT OF HEALTH
SENIOR FARMER'S MARKET NUTRITION PROGRAM (SFMNP)
APPLICATION FOR ELIGIBILITY

Office on Aging Site: _____ Application Date_____/_____/_**2019**

1. **Name:** Last _____ First_____ MI_____

2. **Name:** Last _____ First_____ MI_____
(Spouse applying for SFMNP Benefits)

Address: _____

City_____ County_____Bergen_____ Zip_____

Date of Birth (1) _____Date of Birth (2) _____Telephone Number_____

Check one box:

(1) Ethnicity:
☐ Hispanic
☐ Non-Hispanic

(2) Ethnicity
☐ Hispanic
☐ Non-Hispanic

Check one or more boxes:

(1) Race:
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Black or African American
☐ White

(2) Race:
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Black or African American
☐ White

Identity and residency proof:
☐ Driver License
☐ Utility/Phone Bill
☐ Birth Certificate
☐ Other: _____

Income:
Single $_____per year

Married $_____per year

Income proof:
☐ Current Income Tax Return
☐ Social Security Statement
☐ Food Stamp/SNAP Verification
☐ Medicaid Card

☐ Other: _____

**** If Homeless must Provide at least one form of Identity**
☐ Drivers License, ☐ Birth Certificate, ☐ Social Security Benefit Statement, ☐ Other _____

Rights and Obligations

1. I certify that I am not enrolled in another County Office on Aging and will not try to enroll in another County Office on Aging while enrolled here or will not obtain SFMNP benefits from another County Office on Aging or another site.
2. I understand that I can be disqualified from the program for failure to comply with the SFMNP obligations and regulations, and may result in penalties or in disqualification from the SFMNP for one year.

By my signature, I also understand that the State and local agencies have the option to verify reported income further, in order to confirm my income eligibility for the SFMNP.

I certify that by receiving this SFMNP seasonal benefit checks, I acknowledge that I have read SFMNP's income eligibility guidelines. In addition, I acknowledge that my household income falls within the published annual income guidelines for SFMNP.

I certify that I am a resident of New Jersey and a resident of the county of which I am applying for SFMNP benefits.

I further, certify that I am at least 60 years of age and older, which is the minimum age requirement for participation in the Senior Farmers' Market Nutrition Program.

English
The local agency will make health services and nutrition available to you, and you are encouraged to participate in these services.
I have been advised of my rights and obligations under the Senior Farmers' Market Nutrition Program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted about the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or 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 it is illegal to receive more than one (1) set of SFMNP checks in one (1) calendar year.

(1) Date: _____ _____
Month, day year Signature of participant

(2) Date: _____ _____
Month, day year Signature of participant

☐ **Denied** ☐ ☐ **Approved**

Dated:_____,_____ _____
(Month, day) year (Signature of local agency representative)

If you believe you are eligible for SFMNP benefits, you have the right to a fair hearing regarding this decision by writing, phoning or visiting the local office no later than 60 days from this notification. The fair hearing will be held at the local office. You may bring a witness, friend or lawyer (all legal fees will be your responsibility). The hearing committee will consist of local officials. They will listen to both sides and give an oral decision. During the hearing, you are permitted to state reasons why you believe you should receive SFMNP benefits. The local staff will state the reasons you were denied. You may request copies of the documents used in determining your case. The hearing will be held at a time that is convenient for you, and you will receive a written notice 10 days before the hearing, reminding you of the date, time and place.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.
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.
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