

SFMNP INCOME ELIGIBILITY GUIDELINES

Participation in the Senior Farmers' Market Nutrition Program is limited to those senior citizens who are 60 years and older and whose gross income (i.e., income before deductions for income taxes, Social Security taxes, insurance premiums, bonds, etc.) is equal to or less than the income poverty guidelines increased by 185%.

WIC Income Eligibility Guidelines					
(Effective from July 1, 2020 to June 30, 2021)					
48 Contiguous States, D.C., Guam and Territories					
Family Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
<input type="radio"/> 1	\$23,606	\$1,968	\$984	\$908	\$454
<input type="radio"/> 2	31,894	2,658	1,329	1,227	614
<input type="radio"/> 3	40,182	3,349	1,675	1,546	773
<input type="radio"/> 4	48,470	4,040	2,020	1,865	933
<input type="radio"/> 5	56,758	4,730	2,365	2,183	1,092
<input type="radio"/> 6	65,056	5,421	2,711	2,502	1,251
<input type="radio"/> 7	73,334	6,112	3,056	2,821	1,411
<input type="radio"/> 8	81,622	6,802	3,401	3,140	1,570
Each Add'l Member Add	+ \$8,288	+ \$691	+ \$346	+ \$319	+ \$160

My signature indicates that I have reviewed the income guidelines by household. By signing this I attest that my income is at or below my household size, listed above. I also affirm that I live in Bergen County and I am at least 60 years of age. I understand that if any of these statements are found to be fraudulent, I will be subject to sanctions per the State Policies and Procedures.

Printed Name of Participant/Proxy

_____/_____/2021
Date

Signature of Participant/Proxy

Signature of Spouse

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Office on Aging Site: Bergen County Division of Senior Services Application Date: ___ / ___ / 2021

Name: Last_ (1) _____ First _____ MI _____

Name: Last_ (2) _____ First _____ MI _____
(Spouse applying for SFMNP Benefits)

Address: City _____ County: Bergen Zip _____

Date of Birth (1) _____ Date of Birth (2) _____ Phone.# _____

Check one box for ethnicity. Check one or more boxes for race.

(1) Ethnicity Hispanic Non-Hispanic

(2) Ethnicity Hispanic Non-Hispanic

(1) Race: American Indian or Alaskan Native

(2) Race: American Indian or Alaskan Native

Native Hawaiian or Pacific Islander

Native Hawaiian or Pacific Islander

Asian

Asian

Black or African American

Black or African American

White

White

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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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