

ARKANSAS SENIOR FARMERS' MARKET NUTRITION PROGRAM

2024 APPLICATION TO PARTICIPATE

PRINT CLEARLY

First Name:	Middle Initial:	Last Name:
Residential Address:		Mailing Address (if different)
City:	State:	Zip Code:
Social Security Number:	County:	Phone Number:
Date of Birth:	Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

This data is required by USDA and will not affect your eligibility for benefits.

Ethnicity: (select one) <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	Race: (select one or more) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> African-American <input type="checkbox"/> Pacific Islander/Native Hawaiian	<input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other
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Number in Household:	Monthly Gross Household Income: \$
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Check the following that apply: <input type="checkbox"/> I receive USDA Commodities (Food for Seniors) <input type="checkbox"/> I receive Medicaid or Extra Help <input type="checkbox"/> I receive SNAP <input type="checkbox"/> I receive Supplemental Security Income (SSI) <input type="checkbox"/> I receive Medicare	I am interested in also applying for: <input type="checkbox"/> Medicare Savings Programs <input type="checkbox"/> SNAP <input type="checkbox"/> Medicaid <input type="checkbox"/> Extra Help with Prescription Drug Costs <input type="checkbox"/> Commodities
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Previously received Senior Farmers' Market Coupons:
 Yes YEAR: _____
 No

In accordance with Federal law and U.S. Department of Agriculture policy, this Agency is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, Washington, DC 20250-9410, or call toll free (866)632-9992 (Voice). Individual who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800)845-6136 (Spanish). USDA is an equal opportunity employer.

AFFADAVIT

I hereby apply to participate in the Arkansas Farmers' Market Nutrition Program. I certify that I am 60 years of age or older. I confirm that my gross monthly income is below the income limit and is within the guidelines to be eligible to participate in this program (not more than 185% of poverty). I am an Arkansas resident and a resident of the Area Agency on Aging of Northwest Arkansas service area. I agree to purchase Arkansas grown fresh, unprocessed fruits, vegetables in approved markets and farm stands with the coupons that I receive. I also understand that no change can be given for coupons used for such purchases.

I indicate that neither I nor my household is participating in the SFMNP through more than one service delivery (dual participation is illegal).

I have been advised of my rights and obligations under the SFMNP. 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 in connection with 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 Agency in cash, the value of the food benefits improperly issued to me any may subject me to civil or criminal prosecution under State and Federal law.

I have been advised that it is illegal to be a dual participant in SFMNP. Application to receive coupons in more than one county or under a separate name is illegal and may subject me to civil or criminal prosecution under State and Federal Law.

Standards for eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP by filing for an appeal hearing with the Area Agency on Aging of Northwest Arkansas.

I understand that only one coupon book per household will be issued.

WAITING LIST

Applicants may be placed on a waiting list if there are more applicants than can be served.

Signature:	Date:
Name of Designated Proxy (if applicable):	Relationship:

AAA OFFICE USE ONLY

AAA Staff Name: _____

Application Approved: YES NO Date: _____

SFMNP Voucher Booklet Issued	Beginning Voucher Number	<input style="width:90%;" type="text"/>
	Ending Voucher Number	<input style="width:90%;" type="text"/>

If Application Denied Why:

<input type="checkbox"/> Under age 60	<input type="checkbox"/> Not a resident of Arkansas
<input type="checkbox"/> Income exceeds Eligibility Limit	<input type="checkbox"/> Not a resident of an eligible county
<input type="checkbox"/> Household already receiving coupons through another eligible person	

If Application Denied - Appeals Procedures given to applicant: Yes No
Date: _____

Area Agency on Aging of Northwest Arkansas/DAAS
2024 Senior Farmers' Market Nutrition Program

Authorized Representative

I hereby authorize, _____, to act on my behalf
(Print Name of Representative)

to apply for and/or use Farmers' Market Nutrition Program Coupons issued by
The Area Agency on Aging of Northwest Arkansas to buy fresh locally grown fruits and
vegetables from designated Arkansas Farmers' Markets and Roadside Stands. If produce
is purchased by my authorized representative, the produce will be returned to me for my
benefit.

Senior PRINT name

Senior Signature

Date