DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-40103 (04/2021)

SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP)
ELIGIBILITY AGREEMENT

Completion of this form is voluntary. If it is not completed, the applicant will not be eligible to receive the benefits of the Senior Farmers' Market Nutrition Program.

Name – Applicant (Last, First, MI) (Please Print)		Race (check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Street Address, City, State, Zip Code (Please Print)		
Telephone Number	Date of Birth (MM-DD-YY)	Ethnicity Information (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Email Address _____ Primary Language Spoken if not English _____

- I certify that my household income is at or below 185 percent of the federal poverty guideline (choose one).

Household Size	Monthly Income	Annual Income
1	$1,986	$23,828
2	2,686	32,227
3	3,386	40,626
4	4,086	49,025
5	4,786	57,424
6	5,486	65,823
7	6,186	74,222

For each additional household member, add $**700** monthly, $**8,399** annually.

- I certify that I am 60 years of age or older or I am a Native American 55 years of age or older.
- I certify that I am a resident of _____ county.
- I understand that program vouchers are used for the purchase of locally-grown fresh produce.
- I have received instructions about how and where to use program vouchers as applicable.
- I understand that it is illegal to enroll in this program at more than one location.

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 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. 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.

SIGNATURE – Applicant	Date Signed
☐ I agree that without a copy of my government issued ID my application is incomplete.	
PRINT NAME– Authorized Representative *The area below is for proxies only.*	Date Signed
SIGNATURE – Authorized Representative	Date Signed

SFMNP Agency HUNGER TASK FORCE	**SIGNATURE –** SFMNP Agency Staff	OFFICE USE: Voucher Numbers Issued

This institution is an equal opportunity provider.