

2021 Senior Farmers' Market Nutrition Program

IMPORTANT: This program is seasonal – April 1 to October 31 – and it is very popular. Spaces are extremely limited. Submit your application ASAP. Most counties' spaces fill up by May or June. Late applicants will be wait-listed.

Please mail your completed application to:

Hawaii Foodbank, 2611Kiliha Street, Honolulu, Hawaii 96819

Name (Last, First M.I.) <i>PRINT YOUR NAME CLEARLY!</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)
I certify under penalty of law that all of the following statements are true and correct:		
1. I am at least 60 years of age.		
2. I reside in the county where I am requesting to receive food coupons.		
3. I am making only one request for ten SFMNP food coupons for the 2021 program year.		
4. I meet the total household income requirement stated below.		
1-person household income of less than \$27,417	2-person household income of less than \$37,074	For each additional person, add \$9,657 per additional household member (including children)
Mailing Address (include apartment or unit number) – WRITE CLEARLY!		City, Zip Code
Email Address		Telephone Number

DESIGNATION OF PROXY (Optional)

A “proxy” or “authorized representative” is someone authorized by an eligible participant to act on the participant’s behalf, including submission of application for participation, receipt of coupons, and use of SFMNP coupons at authorized outlets as long as the SFMNP benefits are ultimately received by the eligible senior. IF you want your coupons mailed to your proxy instead of yourself, insert proxy’s address here: _____, Hawaii _____

Proxy Name (Last, First, M.I.)	Relationship	Proxy Phone Number ()
--------------------------------	--------------	---------------------------

ETHNIC BACKGROUND

USDA requires the State to obtain race and ethnic information. This information is solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.

Please check one: Do you consider yourself Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO	Please check all that apply: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White
--	--

Certification Statement

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 of eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

Applicant Signature

Date (MM/DD/YY)

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 complaint 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.

Local Agency approval date: _____, 2021. Coupons issued ##: _____