COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF AGRICULTURAL RESOURCES
SENIOR FARMERS' MARKET NUTRITION PROGRAM

PROXY FORM

RIGHTS AND RESPONSIBILITIES

I am (check one):

□ 60 years of age or older

□ Disabled and living in a housing facility primarily occupied by older individuals where congregate nutrition services are provided.

I understand the income guidelines or have had them explained to me. I certify that my household income is at or below 185 percent of the federal poverty guideline. I have not received farmers' market coupons from any other location.

Household Size	Monthly Income	Annual Income
1	$1,872	$22,459
2	$2,538	$30,451
3	$3,204	$38,443
4	$3,870	$46,435
For larger households, refer to SFMNP Income Eligibility Guidelines.		

Please answer both statements:
These answers are optional. This information will not in any way affect your eligibility and is used for statistical purposes only.

Select 1 or more of the racial categories:
_____American Indian or Alaska Native
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White

Select 1 or more of the ethnic categories:
_____Not Hispanic or Latino
_____Hispanic or Latino

I have been advised of my rights and obligations under this 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 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.

"I _____(applicant) authorize _____(proxy) to apply and receive benefits on my behalf.

Participant Signature;_____ Date:_____

Print Name: _____

Address:_____

City:_____ State__ ZIP_____ Phone: _____

Complete Reverse Side

Proxy Signature;_____ Date:_____

Print Name: _____

Address:_____

City:_____ State__ ZIP_____ Phone: _____

Agency to Complete:

Check numbers Received: From:_____ To: _____

Sponsor Agency:_____

Distribution Site:_____

Distributor Signature: _____

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(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.

This institution is an equal opportunity provider.