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.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,872</td>
<td>$22,459</td>
</tr>
<tr>
<td>2</td>
<td>$2,538</td>
<td>$30,451</td>
</tr>
<tr>
<td>3</td>
<td>$3,204</td>
<td>$38,443</td>
</tr>
<tr>
<td>4</td>
<td>$3,870</td>
<td>$46,435</td>
</tr>
</tbody>
</table>

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.