Senior Farmers' Market Nutrition Program (SFMNP)

2024 Application for Eligibility

Instructions: To receive benefits for fresh, Alaska grown fruits, vegetables, herbs, and Alaska sourced honey, submit this completed application to your nearest participating agency found listed online at: http://health.alaska.gov/dpa/Pages/nutri/fmnp/fmnpsenior.aspx or by calling the State of Alaska at (907) 465-3100. Applications received by the State of Alaska will not be processed.

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address (if different): _____

City: _____ Zip code: _____ Phone Number: _____

How did you hear about the program? Check the one you have currently used.

- ☐ Word of Mouth
- ☐ Smart Phone
- ☐ Newsletter
- ☐ Tablet
- ☐ Other, please describe _____

Please Check all that apply to determine eligibility:

- ☐ I am 60 years old or older as of September 30, 2024
- ☐ I currently live in Alaska

The following are true (check all that apply):

- ☐ I am actively receiving benefits from the Commodity Supplemental Food Program
- ☐ My income is below 185% of the federal poverty level (more information on next page)

Do you consider yourself Hispanic/Latino? (circle one):

- ☐ Yes, I consider myself Hispanic/Latino
- ☐ No, I do not consider myself Hispanic/Latino

Please check all that apply to you:

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White/Caucasian
- ☐ Native Hawaiian or Other Pacific Islander

This information may be shared with the USDA and is used to learn about who our program serves. It does not affect your SFMNP eligibility. If you choose not to answer the following two questions, staff will be required to make a visual determination on your behalf.

By signing this form, you certify that the information you provided on this form is complete and accurate to the best of your knowledge, you will not apply for or receive more than the individual maximum benefit of $40 during the current year, and that you have read and agree to the following: I have been advised of my rights and obligations under the SFMNP. 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. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. I may be added to a waitlist as benefits are issued on a first come, first serve basis.

_____ _____

Participant Signature Date

Agency Use Only:

☐ Proxy form received

Benefits Issued: _____ to _____ Representative Initials: _____

Senior Farmers' Market Nutrition Program (SFMNP)

2024 Application for Eligibility

To be eligible for the Alaska Senior Farmers' Market Nutrition Program, you must:

1) Be at least 60 years old on or before September 30, 2024,
2) Currently live in Alaska, and
3) Fulfill one of the income qualifiers which are: actively participating in CSFP or your current gross income (income before taxes) is below 185% of Federal Poverty Level as shown in the chart below.

Federal Poverty Level Table in effect from May 1, 2024 to September 30, 2024 for ALASKA

Household Size	Annual Income	Monthly Income
1	$34,799	$2,900
2	$47,249	$3,938
3	$59,700	$4,975
4	$72,150	$6,013
5	$84,601	$7,051
6	$97,051	$8,088
7	$109,502	$9,126
8	$121,952	$10,163
For each additional family member add:	$12,451	$1,038

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.