

South Carolina Department of Social Services
SENIOR FARMERS' MARKET NUTRITION PROGRAM APPLICATION

I am applying to receive Seniors Farmers' Market Nutrition Program checks that will be used to purchase eligible fresh produce from authorized farmers at participating farmers' markets and or roadside stands. I understand that I may only receive SFMNP benefits once during each operating season and I provide assurance that I have not already applied for, and received SFMNP benefits prior to the submission of this application for the current season.

SFMNP

Racial / Ethnic Data for statistical purposes only; will not affect consideration of request for assistance.

<input type="checkbox"/> Male <input type="checkbox"/> Female	Racial Category (Check all that apply)
Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White

Name: _____ Age: _____ County of Residence: _____ Phone: _____
 Street Address: _____ City: _____ State: _____ Zip: _____

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 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, 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.

 Applicant/Proxy Signature

 Application Date

This institution is an equal opportunity provider and employer.

ELIGIBILITY DETERMINATION (Completed by Local Agency Staff)

Currently Receives: <input type="checkbox"/> SNAP <input type="checkbox"/> SSI	HH Income Calculation: Total HH Income: _____ Number in HH: _____ (Refer to Income Chart)	Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No If not eligible, give reason for denial below: _____ _____ Local Agency Representative: _____
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IDENTIFICATION NO.

COUPON ISSUANCE

Beginning No.: _____ Ending No.: _____

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 form or letter 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.

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INSTRUCTIONS FOR DSS FORM 3360

A SFMNP Application form must be completed for each person requesting to receive program benefits in order to receive SFMNP checks. Individuals applying on behalf of another person must provide written authorization from the absent person at the time of application. Individuals acting as Power of Attorney for someone do not need written authorization but must present court documents verifying Power of Attorney status.

1. Gender Check the box to indicate the applicant's gender.
2. Ethnicity Check "Yes" or "No" to indicate if the applicant is of Hispanic origin.
3. Applicant's Racial Category Check all that apply to indicate the applicants racial category.
4. Name Self-explanatory.
5. Age Self-explanatory. Must be age 60 at the time of application to qualify.
6. County of Residence Self-explanatory. Must be a resident of the county to qualify.
7. Phone Self-explanatory.
8. Street Address Self-explanatory.
9. City Self-explanatory
10. State Self-explanatory
11. Zip Self-explanatory
12. Applicant Signature Self-explanatory. Proxies must print the name of applicant and sign their name beside the printed name of the absent person.
13. Application Date Self-explanatory.
14. Automatic Qualifier If the applicant receives benefits from the FS Program or receives SSI benefits they be determined income eligible if verification of participation is provided.
15. Income Eligibility Document total household income and the number of persons living together as one economic household and compare to the Federal Income Poverty Guidelines. If income is at or below the limit for the household size, the applicant is eligible.

Income may be self-declared – No verification required.

16. Eligibility Check "Yes" to indicate the individual is eligible. Check "No" to indicate ineligibility and document the reason for ineligibility. Provide applicant with a written notice of ineligibility.

17. Signature Enter the signature of the agency staff person completing the eligibility determination.

18. Identification No. The identification number is composed of the four-digit agency code, and the six-digit birthdate of the applicant. (Example: Applicant in Richland County with a birthdate of June 6, 1945 = 4001060645)

19. Coupon Issuance Document the serial numbers of the first and last checks in the set of five checks being distributed to the applicant.