South Carolina Department of Social Services

SENIOR FARMERS' MARKET NUTRITION PROGRAM Authorized Representative/Proxy Designation Form

I authorize [**_____**] to act as my Authorized Representative and give my permission for a Senior's Farmers' Market Nutrition Program (SFMNP) application to be completed and submitted on my behalf. If approved, my Authorized Representative will receive the SFMNP benefits on my behalf and ensure the benefits are delivered to me in a timely manner. SCDSS will not replace nor be responsible for SFMNP benefits that have been issued to an Authorized Representative and not delivered to the applicant by the documented expiration date.

I understand that I am responsible for the accuracy of all information provided for the eligibility determination, to include name, date of birth, and household composition. I understand that I may be required to repay the State Agency, in cash or money order, the value of food benefits improperly issued to me.

_____ _____

Signature of Applicant Date

☐ **[_____]** has agreed to act in the capacity of an Authorized Representative/Proxy for the above-named applicant in accordance with 7 CFR 249.6(f) for the Senior Farmers' Market Nutrition Program (SFMNP).

_____ _____

Signature of Representative Date

SC Department of Social Services will not replace federal benefits that have been stolen due to criminal activity. Stealing of federal benefits is a criminal offense.