

IMPORTANT: COMPLETE THIS SECTION BEFORE MAILING YOUR APPLICATION.

Select one:

☐ **I'd like to receive a \$50 produce box.** If you select this option, you will receive a one-time box of in-season, locally grown fruits, vegetables, and honey. Items may include onions, corn, tomatoes, carrots, peppers, peaches, and honey. You will receive this box at your county's distribution event.

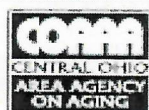
☐ **I'd like to receive \$25 in coupons and a \$25 produce box.** If you select this option, you will receive \$25 in SFMNP coupons that you can use at area community farmers market and roadside stands until 11/30/23, and a \$25 produce box of in-season, locally grown fruits, vegetables, and honey. You will receive your box and coupons at your county's distribution event.

☐ **I'd like to receive 50 in coupons:** If you select this option, you will receive \$50 in SFMNP coupons that you can use at area community farmers market and roadside stands until 11/30/23. You will receive your coupons at your county's distribution event.



2023 APPLICATION

Ohio Department of Aging



LIFECARE ALLIANCE
Respecting The Human Dignity



Franklin County
Board of Commissioners
OFFICE ON AGING



RETURN COMPLETED APPLICATION TO:

LifeCare Alliance SFMNP
670 Harmon Ave.
Columbus, OH 43223 1-614-437-2865

Each applicant must complete and submit a separate application for each program year.

First Name			Middle Initial		Last Name			
Birth Date (mm/dd/yyyy) <i>Must be at least 60 years old to participate</i>					Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> No Answer
Mailing Address								
City			Zip Code		County			
Telephone Number								
Email Address								
Race (select all that apply)								
<input type="checkbox"/> American Indian/Native Alaskan			<input type="checkbox"/> Black/African American			<input type="checkbox"/> White, Non-Hispanic		
<input type="checkbox"/> Asian			<input type="checkbox"/> Native Hawaiian/Other Pacific Islander			<input type="checkbox"/> White, Hispanic		
Nationality (select all that apply)								
<input type="checkbox"/> Hispanic or Latino								
<input type="checkbox"/> Not Hispanic or Latino								
<input type="checkbox"/> Unknown								

Complete the following information **ONLY** if applicant is designating an authorized shopper.

Authorized Shopper Name			
Relationship to Participant		Telephone Number	

Check box corresponding to your **TOTAL** annual household income and household size.

<input type="checkbox"/>	1 person in household with income of \$0-\$26,973	<input type="checkbox"/>	2 persons in household with income of \$0-\$36,482	<input type="checkbox"/>	3 persons in household with income of \$0-\$45,991
<input type="checkbox"/>	4 persons in household with income of \$0-\$55,500	<input type="checkbox"/>	5 persons in household with income of \$0-\$65,009	<input type="checkbox"/>	6 persons in household with income of \$0-\$74,518

I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Farmers' Market Nutrition Program 2023 coupons at any other location; and have a total household income that meets income requirements.

Applicant Signature		Date	
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I have been advised of my rights and obligations under the Ohio Senior Farmers' Market Nutrition Program (SFMNP). I certify the information I have provided is correct. This form is being submitted for Federal Assistance and is subject to verification. I understand that 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. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. Information will not be shared except for the specific purposes of responding to your request for assistance.