Instructions for the 2019 Ohio Senior Farmers' Market Nutrition Program

More vouchers have been made available. We will fill the voucher requests on a first come, first serve basis. If you received an earlier distribution you are NOT eligible for a second distribution.

1. You will want to fill out your form and bring it to:
    a. VANTAGE Aging 2279 Romig Road, Akron, OH 44320
    b. Mail it to: Farmers Market Application, ATTN Karen 2279 Romig Road, Akron, OH 44320
    c. Email it to: referrals@vantageaging.org
2. You may send a proxy, but you must sign the application and the proxy information in the grey box must be complete. The proxy must have a matching photo ID to pick up the vouchers.

Each eligible applicant must complete a separate application.

VANTAGE Promoting A Positive Perspective On Aging	**2019 Ohio Senior Farmers' Market Nutrition Program**	**2279 Romig Road Akron, OH 44320 referrals@vantageaging.org 330-253-4597**

First Name	**Middle Initial**	**Last Name**	
Date of Birth: (mm/dd/yy)		**Age:**	**Sex:** ☐ Male ☐ Female
Mailing Address			**Apt #**
City		***State***	**ZIP Code**
E-mail Address (Optional):			
County (check one): _____Stark _____Summit _____Wayne		**Telephone Number:** ( )	

Ethnicity: (select one) ☐ Not Hispanic/Latino ☐ Hispanic/Latino	**Race:** (select one or more; information collected for federal statistics) ☐ American Indian/Alaskan Native ☐ Pacific Islander/Native Hawaiian ☐ African-American/Non-Hispanic ☐ White ☐ Asian

Please complete the following **ONLY** if you are shopping on behalf of the above applicant such as a caregiver:		
Personal Shopper/Proxy Name (if applicable):	**Relationship to Participant:**	**Contact Number:** ( )
State ID or Driver's License Number:	**Personal Shopper / Proxy Signature:**	

*(Check box corresponding to your **TOTAL** household income)*

☐ **1** person in household income of **$0 - $23,107**	☐ **2** persons in household with income of **$0 - $31,284**	☐ **3** persons in household with income of **$0 - $39,461**
☐ **4** persons in household with income of **$0 - $47,638**	☐ 5 persons in household with income of **$0 - $55,815**	☐ **6** persons in household with income of **$0 - $63,992**

I certify that I am at least 60 years of age; a resident of this service area; have not received coupons at any other location; and total household income requirements are met.

Applicant's Signature:_____ Date: _____

I have been advised of my rights and obligations under the 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.

USDA prohibits discrimination on the basis of race, color, national origin, gender, age, or disability.