




Department of Aging

Senior Farmers Market Nutrition Program

2025 APPLICATION

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|  MEALS on WHEELS <small>NORTHEAST OHIO</small> <small>A PROGRAM OF VANTAGE AGING</small> | AAA10B | RETURN COMPLETED APPLICATION TO: Vantage Aging 2363 Nave Rd. SE Massillon, OH 44646 |
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Each applicant must complete and submit a separate application for each program year. Questions marked with an asterisk (*) are a required field.

| | | | | | |
|-------------|--|----------------|--|------------|--|
| *First Name | | Middle Initial | | *Last Name | |
|-------------|--|----------------|--|------------|--|

| | | | | | |
|---|--|--------|-------------------------------|---------------------------------|------------------------------------|
| *Birth Date (mm/dd/yyyy) <small>Must be at least 60 years old to participate</small> | | Gender | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> No Answer |
|---|--|--------|-------------------------------|---------------------------------|------------------------------------|

| | | | | | |
|------------------|--|--|--|--|--|
| *Mailing Address | | | | | |
|------------------|--|--|--|--|--|

| | | | | | |
|-------|--|-----------|--|---------|--|
| *City | | *Zip Code | | *County | |
|-------|--|-----------|--|---------|--|

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|-------------------|--|--|--|--|--|
| *Telephone Number | | | | | |
|-------------------|--|--|--|--|--|

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

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|--------------------------|--|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | 1 person in household with income of \$0-\$28,953 | <input type="checkbox"/> | 2 person in household with income of \$0-\$39,128 | <input type="checkbox"/> | 3 person in household with income of \$0-\$49,303 |
| <input type="checkbox"/> | 4 person in household with income of \$0-\$59,478 | <input type="checkbox"/> | 5 person in household with income of \$0-\$69,653 | <input type="checkbox"/> | 6 person in household with income of \$0-\$79,828 |

*Receipt of Benefits

Mobile Benefit Option:

I want to use my benefits immediately after approval. I have an email address and a device that can download a mobile application (required for mobile benefit option). An email confirmation from **Support@HomegrownBenefits.com** with instructions for setting up my Homegrown Benefits account and using and monitoring my benefits will be sent to my email address.

Email: _____

Your email address will only be used to establish/verify your account and for reminders to use your benefits should you have a balance remaining at the end of the season. No two applicants can have the same email address. Please create a separate email address per person applying.

Physical Benefit Card Option: (Please Check One)

I do not have a mobile device or would like to request a physical card. By checking this box, I will receive a physical benefit card mailed to the mailing address I provided above within 4-6 weeks. *Please keep the benefit card, as it can be reused if you are approved for benefits in future years. You must reapply every year to have benefits loaded onto the card.*

Reuse your Card: I have my physical card from 2024. My ID# from my previous year's benefit card (circled in the image to the right) is:
ID# _____



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|---|---|--|--|
| Race (Demographic information requested below is completely voluntary and is for reporting purposes only in compliance with requirements for recipients of federal financial assistance. Failure to provide this information will not impact an applicant's eligibility for or participation in the program.) | | | |
| <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 | |
| Ethnicity (Demographic information requested below is completely voluntary and is for reporting purposes only in compliance with requirements for recipients of federal financial assistance. Failure to provide this information will not impact an applicant's eligibility for or participation in the program.) | | | |
| <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 | |
| I have been advised of my rights as included in the nondiscrimination statement provided with this application 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 on this application will not be shared except for the specific purposes of responding to your request for assistance or as required by law. If you have any additional questions, please call 1-866-243-5678 to be connected to your local Area Agency on Aging for assistance. | | | |
| I certify that I am at least 60 years of age, an Ohio resident, and have a total household income that meets the income requirements. I understand that I can only receive \$50 per year, per person benefit and that my benefits are not transferable to another individual(s). I have been offered a copy of the USDA Non-Discrimination Statement. | | | |
| Applicant Signature* | | Date | |

Non-Discrimination Statement

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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.