Virginia Senior Farmers Market Nutrition Program (SFMNP)
District Three Governmental Cooperative 2019 Application

Please Print MUST BE 60 0R OLDER Today's Date: _____/_____/_____

Applicant	**Second Applicant - Same Household Unit**
Name:	Name:
(Last) (First) (MI)	(Last) (First) (MI)
Residence Address:	
(Street)	
(City) (State) (Zip) (County)	
Address to which checks are to be mailed (if different):	
(Street/P.O. Box)	
(City) (State) (Zip)	
( )	
Phone	
Birthdate: ____/____/____	Birthdate: ____/____/____
(Month) (Day) (Year)	(Month) (Day) (Year)

Applicant Demographics		**Second Applicant Demographics**	
Ethnicity: Mark one, regardless of Race	**Race**: Mark one or more	**Ethnicity**: Mark one, regardless of Race	**Race**: Mark one or more
☐ Hispanic or Latino	☐ American Indian or Alaskan Native	☐ Hispanic or Latino	☐ American Indian or Alaskan Native
☐ Not Hispanic or Latino	☐ Asian	☐ Not Hispanic or Latino	☐ Asian
	☐ Black or African American		☐ Black or African American
	☐ Native Hawaiian or Pacific Islander		☐ Native Hawaiian or Pacific Islander
	☐ White		☐ White

Self Declaration for Income Eligibility

Number of People in Household _____

Total Monthly Household Income _____

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Certification - By my signature below I certify that

I understand that it is unlawful to receive farmer's market checks from more than one locality or to enroll in this program more than one time each Market Season. 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 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 my repaying the Virginia Department for the Aging, 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. I understand the Program's household income eligibility guidelines or have had them explained to me. I hereby acknowledge with my signature that my household family income is within the published income eligibility guidelines for participation in SFMNP.

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Signature ↓ Required **Signature ↓ Required**

Signature of Applicant **Date** **Signature of Second Applicant** **Date**

<u>Return Completed Applications To This Address:</u>

District Three Governmental Cooperative
4453 Lee Highway
Marion, VA 24354-4270

Applications will be processed by date received. District Three has a limited number of SFMNP Coupon Books. They are issued to eligible participants on a **First Come – First Served basis. LOST OR STOLEN books will not be replaced. Coupons are mailed sometime in July.**

You should make SURE that you have listed your correct mailing address on this application. You will be notified by mail concerning the result(s) of your application.

MUST BE 60 OR OLDER.

MUST be a resident of VA city of Galax or Bristol, or county of Bland, Carroll, Grayson, Smyth, Washington and Wythe; or one of the major towns of Abingdon, Marion and Wytheville.

Must meet income guidelines.