MARYLAND DEPARTMENT OF AGRICULTURE
SENIOR FARMERS' MARKET NUTRITION PROGRAM
2022 APPLICATION, ELIGIBILITY & PROXY FORM

RIGHTS AND RESPONSIBILITIES
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 the 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 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.

Standards for eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

By signing the check register, I acknowledge that I am 60 years of age AND my household income is within the income eligibility guidelines effective for July 1, 2022 to June 30, 2023.

Household Size	185%				
	Annual	Monthly	Twice Monthly	Bi Weekly	Weekly
48 Contiguous States, D.C., Guam and Territories					
1	$25,142	$2,096	$1,048	$967	$484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
Each add'l fam mem add	+$8,732	+$728	+$364	+$336	+$168

Participant Name: ______________________________ (Person the checks are for)
Residence Address:______________________________
Date:__________________________ **Telephone Number:** ______________
Birthday: _________________ **(month/year)**

Please circle the most appropriate identifier for each:
Ethnicity: • Hispanic or Latino • Not Hispanic or Latino
Race: • American Indian or Alaskan Native • Asian • Black or African American
• Native Hawaiian or other Pacific Islander • White

Each qualified senior may only receive the $35 SFMNP benefit 1x each year.

I hereby acknowledge with my signature that I am a Maryland resident, I am 60 years or older and my household income is within the income guidelines referenced above for participation in SFMNP. I also acknowledge that I will not seek SFMNP checks from any other location after I have received them here.

Participant's Signature ____________________________ (Person checks are for)
Staff Signature: ___________________________________
Agency Name: ____________________________________
Date of Certification: ___________________________
Sequence of Checks Distributed: Check #_____________ **- Check #**__________
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*** If the Participant is using a Proxy to pick up the Checks**

This portion must be filled out.

**The proxy must take this form to a distribution site in the county the participant resides within.

Proxy Name: **Date:** ________________ (Person picking up the checks)

Proxy Signature _______________________________ (Person picking up checks)
Staff Signature: ___________________________________
Agency Name: ____________________________________
Date of Certification: ___________________________
Sequence of Checks Distributed: Check #_____________ **- Check #**_________

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form,(AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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