**2021 SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP)**
**SENIOR PARTICIPANT PROXY FORM**

*If a senior participant is unable to go to a local office to receive the SFMNP checks or to a farmers' market to redeem their SFMNP checks, a proxy may go in their stead. This form must be completed by the eligible participant to allow for a proxy. This must be retained by the local office for a minimum of three years.*

PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

I am (check one):

□ 60 years of age or older □ Disabled and living in a housing facility primarily occupied by older individuals where congregate nutrition services are provided.

I understand the income guidelines or have had them explained to me. I certify that my household income is at or below 185 percent of the federal poverty guideline. I have not received farmers' market coupons from any other location.

**2021 Income Limits**

| Household Size | Monthly Income | Annual Income |
|---|---|---|
| 1 | $1,986 | $23,828 |
| 2 | $2,686 | $32,227 |
| 3 | $3,386 | $40,626 |
| 4 | $4,086 | $49,025 |
| 5 | $4,786 | $57,424 |
| 6 | $5,486 | $65,823 |
| 7 | $6,186 | $74,222 |
| 8 | $6,886 | $82,621 |

I have been advised of my rights and obligations for this program. I certify the information I have provided for 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 I may appeal a decision made by the local agency regarding my eligibility for the SFMNP.

PROXY RELEASE

"I ______________________ (applicant) authorize ______________________ (proxy) to apply and receive benefits on my behalf.

Participant Signature;______________________ Date:____________

Print Name:______________________

Address:______________________

City:____________ State:____ Zip:________ Phone:____________

These answers are optional. **Please answer both statements:** This information will not affect your eligibility.

**Select 1 or more of the racial categories:**

_____American Indian or Alaska Native
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White

**Select 1 or more of the ethnic categories:**

_____Not Hispanic or Latino
_____Hispanic or Latino

**COMPLETE REVERSE SIDE**

# STATE OF CONNECTICUT
## DEPARTMENT OF AGRICULTURE
### Bureau of Ag Development & Resource Conservation

Bryan P. Hurlburt
Commissioner

860-713-2501
CTGrown.gov


**PROXY INFORMATION**

Proxy Signature:________________________________ Date: ____________________

Print Name: ______________________________________

Address: _________________________________________________________________

City:_____________________ State:____ Zip:_________

Phone:_________________________

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**LOCAL AGENCY TO COMPLETE**

Check numbers Received: From:______________ To: ________________

Distribution Site:_______________________________________________________________

Distributor Name and Title: _______________________________________________________:

Signature: _____________________________________________________________________

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(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.