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

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,986</td>
<td>$23,828</td>
</tr>
<tr>
<td>2</td>
<td>$2,686</td>
<td>$32,227</td>
</tr>
<tr>
<td>3</td>
<td>$3,386</td>
<td>$40,626</td>
</tr>
<tr>
<td>4</td>
<td>$4,086</td>
<td>$49,025</td>
</tr>
<tr>
<td>5</td>
<td>$4,786</td>
<td>$57,424</td>
</tr>
<tr>
<td>6</td>
<td>$5,486</td>
<td>$65,823</td>
</tr>
<tr>
<td>7</td>
<td>$6,186</td>
<td>$74,222</td>
</tr>
<tr>
<td>8</td>
<td>$6,886</td>
<td>$82,621</td>
</tr>
</tbody>
</table>

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

________________________________________ (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
PROXY INFORMATION

Proxy Signature: ___________________________ Date: ___________________________

Print Name: ________________________________

Address: ___________________________________

City: __________________ State: ____ Zip: _______

Phone: ___________________________


LOCAL AGENCY TO COMPLETE

Check numbers Received: From: ____________ To: ____________

Distribution Site: ____________________________

Distributor Name and Title: _________________________________

Signature: ___________________________

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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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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