2019 Senior Farmers' Market Nutrition Program

DEADLINE: Applications must be RECEIVED by Friday, September 20, 2019.

Please mail completed application to:
Hawaii Foodbank
2611 Kilihau Street, Honolulu, HI 96819

Name (Last, First, M.I.)	☐ Male ☐ Female	**Date of Birth (MM/DD/YYYY)**

I certify that **all** of the following statements are true and correct:
1. I am at least 60 years of age.
2. I reside in the county of Honolulu.
3. I have not received coupons at any other location for the 2019 program year.
4. I meet the total household income requirement stated below.

1 person household income of less than $26,603	2 person household income of less than $36,001.	For each additional person, add $9,398 per additional household member (including children)

Mailing Address (Include apartment or unit number)	**City, Zip Code**
Email Address	**Telephone Number**

DESIGNATION OF A PROXY (Optional)

A "proxy" or "authorized representative" is defined as an individual authorized by an eligible participant to act on the participant's behalf, including submission of application for certification, receipt of SFMNP coupons or other benefits, or use of SFMNP coupons at authorized outlets as long as the SFMNP benefits are ultimately received by the eligible senior.

Proxy Name (Last, First, M.I)	**Relationship**	**Proxy Phone Number** ( )

ETHNIC BACKROUND

USDA requires the State to obtain race and ethnic information. This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.

Please check one:	**Please check all that apply:**	
Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No	☐ American Indian or Alaskan Native	☐ Asian
	☐ Black or African American	☐ White
	☐ Native Hawaiian or Other Pacific Islander	

Certification Statement

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, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

_____ **Applicant Signature**

_____ **Date (MM/DD/YY)**

This institution is an equal opportunity provider

For Official Use Only:
Coupon #_____