

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGRICULTURE
SENIOR FARMERS' MARKET NUTRITION PROGRAM

2026 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.

Participant Name (print): _____ **Birth Date** _____
(Person checks are for)

Address: _____

Telephone Number: _____

Please check the box of the most appropriate identifier for each:

Ethnicity: 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

By signing this proxy for I acknowledge that my total household income is within the Income guidelines: **\$29,526** for 1 person in the household; or **\$40,034** for 2 people in the household and that I am 60 years old or older.

Participant's Signature _____ (Person checks are for)

Proxy Name (print): _____

(Person picking up the checks for participant)

Proxy's Signature _____

Address: _____

Telephone Number: _____

Check Numbers Received: _____

****The proxy must take this form to a distribution site in the county the participant resides in. DO NOT MAIL**