Ohio | Department of Aging

APPLICATION

Ohio Senior Famers' Market Nutrition Program 2021

Western Reserve Area Agency on Aging
AAA10A

RETURN COMPLETED APPLICATION TO:

Western Reserve Area Agency on Aging
1700 E. 13th St., Suite 114
Cleveland, OH 44114-3285 216-672-5740

Each applicant must complete and submit a separate application for each program year.

First Name			Last Name							
Date of Birth (mm/dd/yyyy)			Gender	☐	Male	☐	Female	☐	No Answer	
Mailing Address										
City		Zip Code		County						
Telephone Number										
Email Address										

Race (select all that apply)	☐	American Indian/Native Alaskan	☐	Native Hawaiian/Pacific Islander
	☐	Asian	☐	White
	☐	Black/African American	☐	Other
Nationality (select all that apply)	☐	Arabic	☐	Hawaii, Guam, Samoa, Pacific Islands origin
	☐	Chinese	☐	Of Spanish origin or culture, regardless of race
	☐	Europe, the middle east, or North African origins	☐	Origins in black racial groups of Africa
	☐	Far East, Southeast Asia, Indian subcontinent origins	☐	Of an ethnic race other than those listed

Complete the following information ONLY if applicant is designating an authorized shopper.

Authorized Shopper Name			
Relationship to Participant		Telephone Number	

Check box corresponding to your TOTAL annual household income

☐	1 person in household with income of $0 - $23,828	☐	2 persons in household with income of $0 - $32,227	☐	3 persons in household with income of $0 - $40,626
☐	4 persons in household with income of $0 - $49,025	☐	5 persons in household with income of $0 - $57,424	☐	6 persons in household with income of $0 - $65,823

I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Famers' Market Nutrition Program 2021 coupons at any other location; and have a total household income that meets income requirements.

Applicant Signature		Date	

I have been advised of my rights and obligations under the Ohio Senior Farmers' Market Nutrition Program (SFMNP). I certify the information I have provided is correct. This form is being submitted for Federal Assistance and is subject to verification. I understand that 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. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. Information will not be shared except for the specific purposes of responding to your request for assistance.