





2022 APPLICATION



		<p>RETURN COMPLETED APPLICATION TO:</p> <p>Homefull 2003 Springboro W. Road, Moraine, Ohio 45439 937-262-4618</p>
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Each applicant must complete and submit a separate application for each program year.

First Name	Middle Initial	Last Name
Birth Date (mm/dd/yyyy) <i>Must be at least 60 years old to participate</i>		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No Answer
Mailing Address		
City	Zip Code	County
Telephone Number		
Email Address		
Race (select all that apply)		
<input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> White, Hispanic
Nationality (select all that apply)		
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		

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 and household size.

<input type="checkbox"/>	1 person in household with income of \$0-\$25,142	<input type="checkbox"/>	2 persons in household with income of \$0-\$33,874
<input type="checkbox"/>	3 persons in household with income of \$0-\$42,606	<input type="checkbox"/>	4 persons in household with income of \$0-\$51,338
<input type="checkbox"/>	5 persons in household with income of \$0-\$60,070	<input type="checkbox"/>	6 persons in household with income of \$0-\$68,802

I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Farmers' Market Nutrition Program 2022 coupons at any other location; and have a total household income that meets income requirements.

Applicant Signature	Date
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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.