Senior Farmers’ Market Nutrition Program (SFMNP)
2023 Application for Eligibility

INSTRUCTIONS: To receive benefits to purchase fresh, Alaska grown fruits, vegetables, herbs, and Alaska sourced honey, submit this completed application to your nearest participating agency found listed online at: http://dhss.alaska.gov/dpa/Pages/nutri/fmnp/fmnp SENIOR.aspx or by calling the State of Alaska at (907) 465-3100. Applications received by the State of Alaska will not be processed. All Fields with an asterisk (*) are required.

*Name: ________________________________  *Birth date: ______ / ______ / ________

*Mailing Address: __________________________________________________________

*City: _______________ Zip code: ___________ Phone Number: (______)________

Optional Questions:
Check any that you currently have and use: □ Smartphone □ Tablet □ None

Please check all that apply to determine eligibility:
□ I am 60 years old or older as of September 30, 2023
□ I currently live in Alaska.
The following are true (check all that apply):
□ I am actively receiving benefits from the Commodity Supplemental Food Program.
□ My income is below 185% of the federal poverty level. (more information on next page)

This information may be shared with the USDA and is used to learn about who our program serves. It does not affect your SFMNP eligibility. If you choose not to answer the following two questions, staff will be required to make a visual determination on your behalf if able.

Please check all that apply to you:
□ Black or African American □ White/Caucasian
□ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander
□ Asian

Do you consider yourself Hispanic/Latino?
□ Yes □ No

By signing this form, you certify that the information you provided on this form is complete and accurate to the best of your knowledge, you will not apply for or receive more than the individual maximum benefit of $40 during the current year, and that you have read and agree to the following: I have been advised of my rights and obligations under the SFMNP. This 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 benefits improperly issued to me and I may be subject prosecution under State and Federal law. Standards for eligibility and participation are the same for everyone. I understand that I may appeal any decision made regarding my eligibility. I may be added to a waitlist.

*Participant Signature _______________  *Date ___________ / _________ / ________

Agency Use Only: Checks Issued: _______________ to _______________
Representative Initials: _______________ □ Proxy form received Form revised 4/19/2023