2026 NORTH CAROLINA Seniors Farmers' Market Nutrition Program (SFMNP)

(To be completed by local agency.) Return Application to:

2026 SFMNP PARTICIPANT APPLICATION

Name:_____ Date of Birth (month/day/year):____ / ____ /_____

Address:_____ Apt./Box #:_____

City:_____ Zip code:_____ County of Residence:_____

Phone: (____) _____ - _____ Email address:_____

1. **Self-Declared Income Eligibility – Please check the box that applies to you.***

   ☐ My household income is at or **less** than $2,461/month for 1 person or $3,337/month for 2 people.

   ☐ My household income is **more** than $2,461/month for 1 person or $3,337/month for 2 people.

2. **Do you consider yourself Hispanic/Latino?** (Please check one.) ☐ Yes ☐ No

3. **Racial Identity - Please check all that apply:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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.

By signing this form, I certify that I meet the all the eligibility requirements above and acknowledge that I have been given SFMNP Rights and Responsibilities information.

Participant/Proxy Signature: _____ Date:____ / ____ /_____

This section to be completed by local agency ONLY. *For households larger than 2 people, refer to the 2026-2027 SFMNP Income Eligibility Guidelines.

Eligible: ☐ Yes ☐ No If not eligible, give reason for denial:_____

Local Agency Representative Signature:_____

Date of determination:____ / ____ /_____

Voucher Booklet Starting Serial Number: (e.g., 555001) _____

This institution is an equal opportunity provider.

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Seniors Farmers' Market Nutrition Program (SFMNP)

2026 SFMNP PROXY FORM

Proxy means an individual authorized by an eligible participant to act on the participant's behalf, including application for certification, receipt of SFMNP vouchers or other benefits, and use of SFMNP vouchers at authorized markets, as long as the SFMNP benefits are ultimately received by the eligible participant. (7 CFR 249.2 "Proxy")

Local agencies must obtain a signed statement from the eligible participant designating another individual as his/her proxy if the participant is unable to apply for the SFMNP or shop with the vouchers. Local agencies should use this form for eligible participants to designate proxies. A participant who has been certified to receive SFMNP benefits may designate a proxy at any point during the SFMNP months of operation. (7 CFR 249.6(f))

For vouchers to be issued to a proxy, the proxy must present identification and written approval from participant.

- Proxies must sign the voucher issuance log to receive vouchers and are authorized to sign individual vouchers on behalf of eligible participants.
- Proxies must follow all program guidelines when purchasing fruits, vegetables, raw honey, and fresh cut herbs from SFMNP-certified farmers for eligible participants.
- Proxies must be at least eighteen (18) years of age and dependable for the duration of the program months of operation.
- Proxies must **not** be employees with the local agency issuing the SFMNP vouchers.

Name of participant:_____ County of Residence:_____

I, _____, authorize the following individual(s) to act as my proxy:
Participant signature

Name of Proxy 1:_____
Proxy 1 Email:_____ Proxy 1 Phone: (____) _____ - _____

Name of Proxy 2:_____
Proxy 2 Email:_____ Proxy 2 Phone: (____) _____ - _____

Date:____ / ____ /_____

Nondiscrimination Statement

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: 1.) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; 2.) Fax: (202) 690-7442; or 3.) Email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.