SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP)

2024 Income Eligibility Table

Effective: **June 1, 2024** Based on 185% of the US Dept. of **2024** Health and Human Services Poverty Guidelines.			
Use total gross income – before taxes and deductions - of ALL household members.			
Household Size	**Yearly**	**Monthly**	**Weekly**
1	$27,861	$2,322	$536
2	$37,814	$3,152	$728
3	$47,767	$3,981	$919
4	$57,720	$4,810	$1,110
5	$67,673	$5,640	$1,302
6	$77,626	$6,469	$1,493
7	$87,579	$7,299	$1,685
8	$97,532	$8,128	$1,876
Each additional household member	$9,553	$830	$192

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-40103 (07/2023)

SENIOR FARMERS' MARKET NUTRITION PROGRAM (SFMNP) ELIGIBILITY AGREEMENT

Completion of this form is voluntary. If it is not completed, the applicant will not be eligible to receive the benefits of the Senior Farmers' Market Nutrition Program.

Name – Applicant (Last, First, MI) (Please Print)		Ethnicity Information (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Street Address (Please Print)		
City, State, Zip Code (Please Print)		Race (check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Telephone Number	Date of Birth (MM-DD-YY)	

Primary Language Spoken if not English _____

- I certify that my household income is at or below 185 percent of the federal poverty guideline.
  ☐ I have viewed the current year's SFMNP Income Eligibility Table.
- I certify that I am 60 years of age or older or I am a Native American 55 years of age or older.
- I certify that I am a resident of _____ county.
- I understand that program vouchers are used for the purchase of locally-grown fresh produce.
- I have received instructions about how and where to use program vouchers as applicable
- I understand that it is illegal to enroll in this program at more than one location.
- I have designated _____ to be my authorized representative.

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, sex (including gender identity and sexual orientation), disability, age, or prior civil rights activity. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

SIGNATURE – Applicant	Date Signed
SIGNATURE – Authorized Representative	Date Signed
SIGNATURE – SFMNP Agency	Check Numbers Issued

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.