

For office use only
Application _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGRICULTURE
SENIOR FARMERS' MARKET NUTRITION PROGRAM

2025 APPLICATION FORM

To qualify, you must be 60 or older (or turn 60 by 12/31/2025) and meet the household income guidelines.

RIGHTS AND RESPONSIBILITIES

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, I acknowledge that my total household income is within the Income guidelines: **\$28,953** for 1 person in the household; or **\$39,128** for 2 people in the household and that I am 60 years old or older (or will turn 60 by 12/31/2025).

1st Participant Name (print): _____ **Birth Date** _____
(Person checks are for)

(Signature)

2nd Participant Name (print): _____ **Birth Date** _____
(Person checks are for)

(Signature)

Address (print): _____
(Street) (City) (State) (Zip Code)

Telephone Number: _____ **County of residence:** _____

☐ I will/have watched the "My Plate for Older Adults" video prior to redeeming my SFMNP vouchers.

Please circle appropriate identifier for each:

Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander White

Check Range: _____ **(Office Use Only)**

Please see back for USDA Nondiscrimination Statement

PLEASE MAIL APPLICATION TO COUNTY AGING OFFICE IF APPLICABLE
LAST DAY TO RECEIVE CHECKS: 9/30/25

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and 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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. 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 <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf> 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
Washington, D.C. 20250-9410; or
2. **fax:**
(202) 690-7442; or
3. **email:**
Program.Intake@usda.gov

This institution is an equal opportunity provider.

Additional Information Needed: Informational Only- (Does not affect eligibility for program)

Social Security # Participant # 1: _____

Social Security # Participant # 2: _____

Gender Identity: Participant # 1: _____ Gender Identity: Participant # 2: _____

Municipality/Township/Borough: _____

Living Arrangement: (Circle)	Lives Alone	Lives with Spouse
	Lives with Other Family Member	Other

For 2025, is your annual income below 125% of the current Federal Poverty Income (see below)? YES NO

1 person: \$18,825 2 people: \$25,550 3 people: \$32,275

Would you like to sign up for our newsletter or other communications?

If so, please provide your email address. _____

LAST DAY TO RECEIVE CHECKS: 9/30/25