Attachment C

Rev 05/4/2023

NEW YORK STATE OF OPPORTUNITY | Agriculture and Markets

Senior Farmers Market Nutrition Program (SFMNP)

STATEMENT OF ELIGIBILITY

Complete the following chart. The answers you provide in this chart are optional and will not affect your eligibility for the SFMNP. Standards for eligibility and participation in the SFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex.

Ethnicity (select yes or no) Hispanic or Latino?			**Race** (select one or more)			
Yes	**No**	**American Indian or Native Alaskan**	**Asian**	**Black or African American**	**Native Hawaiian or Pacific Islander**	**White**

I certify that:

I. I am:
   a. 60 years of age or older; AND
   b. My monthly income is at or below the federal income guidelines for my household outlined in SFMNP Policy Memorandum #2023-1.
      i. $2,248/month (for a one-person household); Or
      ii. $3,041/month (for a two-person household); Or
      iii. $3,833/month (for a three-person household).

II. I have not received SFMNP checks from any other location this year.

III. I have been advised of my rights and obligations under the SFMNP. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP.

IV. 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.

_____ _____

Signature (Participant) **Date**

****Internal Use Only****

Booklet Serial Number: **501213071-3075** Program/Agency Name: **RCOFA** Site ID: **53800**

Program/Agency Representative's Name (Issuer): _____