



Kentucky Department of Agriculture Senior Farmers' Market Nutrition Program

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Certificate of Eligibility

Instructions: All sections of this form are required information for participating in this program. Be sure to fill in check numbers. Information must also be recorded on the Check Issuance Log Form. Match and attach this form to the log form. Detailed instructions provided in your local issuing agency packet.

Participant Information			
Participant Name _____	Birth date _____ / _____ / _____		
Address _____	City _____	State _____	Zip _____

"This information is requested solely for the purposes of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a non-discriminatory manner."

Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> American Indian or Alaska Native and White	<input type="checkbox"/> Asian and White	<input type="checkbox"/> Black or African American and White	<input type="checkbox"/> American Indian or Alaska Native and Black or African American
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ELIGIBILITY REQUIREMENTS			
Age – Person must be 60 years of age or older on the day of issuance.			
Verified by			
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> US Census Records	<input type="checkbox"/> Baptismal Record	
<input type="checkbox"/> Driver's License	<input type="checkbox"/> Military/Veteran's ID Card	<input type="checkbox"/> Bible Record	
<input type="checkbox"/> School Record	<input type="checkbox"/> Notarized Affidavit of Birth	<input type="checkbox"/> Other _____	
Income Level			
Total annual income for the household must not exceed those on the local guidelines. See agency staff to review the income levels.			
Number in Household _____			
Income \$ _____			
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			
Verified by: <input type="checkbox"/> Bank Statement <input type="checkbox"/> Check Stub <input type="checkbox"/> CSFP recipient <input type="checkbox"/> Food Stamp recipient			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____			

SIGNATURE OF RECEIVED CHECKS	
I, the undersigned, acknowledge that after an explanation of the eligibility requirements for the Seniors Farmers' Market Nutrition Program (SrFMNP), I am eligible to receive SrFMNP check booklets. On this _____ day of _____, 201____, I have received my SrFMNP benefits. I understand that I can only receive SrFMNP benefits once per year. I understand that misrepresentation of eligibility may result in legal action to collect funds paid out to any person not meeting the eligibility requirements stated above.	
Designation of Proxy <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, I designate	
<input checked="" type="checkbox"/> _____	Date _____
Participant	

CHECKS ISSUED	Number of Checks Issued <u> 7 </u>
Check Start Number _____	
FOR USE BY LOCAL ISSUING AGENCY	
<input checked="" type="checkbox"/> _____	
Information Verified by _____	Agency _____