



**Kentucky Department of Agriculture**  
**Senior Farmers' Market Nutrition Program**  
 107 Corporate Drive, Frankfort, KY 40601 • (502) 573-0282

**Certificate of Eligibility**

**\*\*Instructions: All sections of this form are required information for participating in this program. Be sure to complete all sections fully including card number. Information must also match and be recorded on the Card Issuance Log.\*\***

**Participant Information**

Participant Name	/ /	Date of Birth	Phone Number
Address	City	State	Zip

**Ethnicity:**

*Please select one or more:*

- Hispanic or Latino  
 Not Hispanic or Latino

**Race:**

*Please select one or more:*

- American Indian or Alaskan Native  
 Black or African American  
 Asian  
 White  
 Native Hawaiian or Other Pacific Islander

**Eligibility Requirements**

**Age- Participant must be 60 years of age or older on the day of issuance.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Birth Certificate         | <input type="checkbox"/> School Record              | <input type="checkbox"/> Bible Record                 | <input type="checkbox"/> Baptismal Record |
| <input type="checkbox"/> Drivers' License/State ID | <input type="checkbox"/> Military/Veteran's ID Card | <input type="checkbox"/> Notarized Affidavit of Birth | <input type="checkbox"/> Other: _____     |

**Income Level**

**Total annual income for the household must be less than or equal to 185% of federal poverty level. Please see current program year income levels provided by local distribution agency staff.**

*Household means a group of related or nonrelated individuals who are living together as one economic unit.*

**I self-declare that I meet the following federal income guidelines to participate in this program.**

**Household Size:** \_\_\_\_\_ **Annual Income of Household:** \_\_\_\_\_ **or Monthly Income of Household:** \_\_\_\_\_

**Signature of Received Checks including Rights and Responsibilities**

*I, have been advised of my rights and obligations under SFMNP. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. Upon verification of this information I understand any false, misleading, intentionally misrepresenting, concealing or withholding facts may result in reimbursement in cash the value of food benefits to the State agency and may subject me to civil or criminal prosecution under State and Federal Law. I understand that I may appeal any decision made by the local agency regarding my eligibility for SFMNP.*

Designation of Proxy:  Yes  No      *If yes, I designate:* \_\_\_\_\_ *and/or* \_\_\_\_\_

Participant Signature:  \_\_\_\_\_      Date: \_\_\_\_\_

**For use by Local Distribution Agency Card Issue**

Card Number with 2-digit prefix: (\_\_\_\_) - \_\_\_\_\_

*I hereby certify that this assessment was made on the basis of information provided by the participant. All eligibility criteria were applied as defined by the Kentucky Department of Agriculture Division of Food Distribution.*

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Distribution Agent      Agency      Date

**The Kentucky Department of Agriculture does not discriminate on the basis of race, color, religion, gender, national origin, age or disability in employment or the provision of services. Reasonable accommodations are provided upon request.**

**This institution is an equal opportunity provider.**

*For complete USDA Non Discrimination Statement please visit: <http://www.kyagr.com/consumer/senior-farmer-market.html>*