

For office use only  
Application \_\_\_\_\_

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

## FARMERS MARKET FRUIT & VEGETABLE VOUCHER

### NEW PROCESS

Take an **APPLICATION**...

Complete form in its entirety and **bring with you to redeem** at one of the following locations...

- Meadville Active Aging on **Tuesday, 6/16 between 2-6PM**  
1034 Park Ave Meadville PA 16335  
**WATCH for PARKING LOT signage**  
814-336-1792 x 106
- Lakeland Active Aging on **Wednesday 6/17 between 2-5PM**  
237 S Pymatuning St **PARKING LOT** – Linesville PA 16424  
814-683-4959
- Cambridge Active Aging on **Thursday 6/18 between 2-5PM**  
Fireman's Carnival Grounds (off Snow Ally) – Cambridge PA 16403  
**WATCH for Directional signage**  
814-398-8616

One application is good for a married couple.

Proxy forms are not needed provided the **participant** can sign the application.

Call the appropriate location if you have questions on completing the application.

This institution is an equal opportunity provider.

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## 2020 Application Form

To qualify you must be 60 or older (or turn 60 by 12/31/2020) and meet the household income guidelines.

### RIGHTS AND RESPONSIBILITIES

I certify that the information I have provided below 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: \$23,606 for 1 person in the household; or \$31,894 for 2 people in the household and that I am 60 years old or older (or will turn 60 by December 31, 2020).**

1<sup>st</sup> Participant Name (print): \_\_\_\_\_ Birth date \_\_\_\_\_  
(Person checks are for)

\_\_\_\_\_  
(Signature)

2nd Participant Name (print): \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Person checks are for)

\_\_\_\_\_  
(Signature)

Address (print): \_\_\_\_\_

Telephone Number: \_\_\_\_\_ County you live in \_\_\_\_\_

Please circle the most appropriate identifier for each:

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

If more responses are received than funding allows you will be notified by mail.

Please mail or email your completed form before September 30, 2020 to:

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