



SENIOR FARMERS MARKET NUTRITION PROGRAM

RHODE ISLAND SFMNP

dem.ri.gov/sfmnp

2025 SFMNP Benefit Eligibility Application

Number of family members:	Annual Gross Income:
1	$ 28,953
2	$ 39,128
3	$ 49,303
4	$ 59,478
Each additional member add $ 10,175	

1) **Are you 60+ years of age, or are you disabled while currently living in housing facilities where congregate nutrition services are provided?**
   Yes: ☐ **No: ☐**
2) **Do you earn less than the income stated above?**
   Yes: ☐ **No: ☐**
3) **Are you a Rhode Island resident?**
   Yes: ☐ **No: ☐**

If you answered "yes" to questions #1-3, you are considered eligible to receive a Senior Farmers Market Nutrition Program (SFMNP) electronic benefit card for the 2024 season. Each eligible RI residents may only receive a maximum of one electronic benefits card.

Proxy: I give permission for_____ to pick up an electronic benefit card on my behalf and/or redeem benefits on my electronic benefits card at authorized farmers markets and roadside stands on my behalf.

Applicant Signature: _____ Date: _____

Phone Number: _____ Zip Code: _____

Racial Category: American Indian, Asian, African American, Pacific Islander, White

Ethnic Category (circle): Hispanic/Latino or Not Hispanic/Latino

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For SFMNP Eligible Participants:

I have been advised of my rights and obligations under the SFMNP. 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.

Non-Discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

Mail:	**Fax:**	**Email:**
U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410	(833) 256-1665 or (202) 690-7442	program.intake@usda.gov

This institution is an equal opportunity provider.

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