Rhode Island Department of Environmental Management

Senior Farmers' Market Nutrition Program (SFMNP) Eligibility & Reporting Form

Issuing Agency: _____

Agency Address: _____

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.

Issuing Staff Name: _____   Issuing Staff Signature: _____

Eligible Participant's Name (please print)	Racial Category	Ethnic Category	Participant's Signature upon receiving produce box	Proxy's Signature upon receiving produce box	Date of Pickup

Eligible Participant's Name (please print)	Racial Category	Ethnic Category	Participant's Signature upon receiving produce box	Proxy's Signature upon receiving produce box	Date of Pickup

Please answer both statements in appropriate column (use appropriate code in bold): These answers are optional. This information will not affect your eligibility.

Select 1 or more of the racial categories:

_AI_ American Indian or Alaska Native

_A_ Asian

_BA_ Black or African American

NHP Native Hawaiian or Other Pacific Islander

_W_ White

Select 1 of the ethnic categories:

NHL Not Hispanic or Latino

__HL___ Hispanic or Latino

This institution is an equal opportunity provider.