

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

PROXY FORM

RIGHTS AND RESPONSIBILITIES

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.

Participant Name: _____ Date _____

Address: _____

Telephone Number: _____

Race _____

Proxy Name: _____ Date _____

Address: _____

I hereby acknowledge with my signature that I am a Pennsylvania resident, I am 60 years or older and my household income is within the income guidelines for participation in SFMNP.

Participants Signature _____

Proxy Signature _____

Check numbers Received: _____, _____, _____, _____