



2022 APPLICATION



Western Reserve Area Agency on Aging AAA10A		RETURN COMPLETED APPLICATION TO: Western Reserve Area Agency on Aging 1700 E. 13th St., Suite 114 Cleveland, OH 44114-3285 216-672-5740
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Each applicant must complete and submit a separate application for each program year.

First Name	Middle Initial	Last Name			
Birth Date (mm/dd/yyyy) <i>Must be at least 60 years old to participate</i>		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> No Answer
Mailing Address					
City	Zip Code	County			
Telephone Number					
Email Address					
Race (select all that apply)					
<input type="checkbox"/> American Indian/Native Alaskan		<input type="checkbox"/> Black/African American		<input type="checkbox"/> White, Non-Hispanic	
<input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander		<input type="checkbox"/> White, Hispanic	
Nationality (select all that apply)					
<input type="checkbox"/> Hispanic or Latino					
<input type="checkbox"/> Not Hispanic or Latino					
<input type="checkbox"/> Unknown					

Complete the following information **ONLY** if applicant is designating an authorized shopper.

Authorized Shopper Name			
Relationship to Participant	Telephone Number		

Check box corresponding to your **TOTAL** annual household income and household size.

<input type="checkbox"/>	1 person in household with income of \$0-\$25,142	<input type="checkbox"/>	2 persons in household with income of \$0-\$33,874	<input type="checkbox"/>	3 persons in household with income of \$0-\$42,606
<input type="checkbox"/>	4 persons in household with income of \$0-\$51,338	<input type="checkbox"/>	5 persons in household with income of \$0-\$60,070	<input type="checkbox"/>	6 persons in household with income of \$0-\$68,802

I certify that I am at least 60 years of age; a resident of this service area; have not received Ohio Senior Farmers' Market Nutrition Program 2022 coupons at any other location; and have a total household income that meets income requirements.

Applicant Signature	Date	
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I have been advised of my rights and obligations under the Ohio Senior Farmers' Market Nutrition Program (SFMNP). I certify the the information I have provided is correct. This form is being submitted for Federal Assistance and is subject to verification. I understand that 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. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. Information will not be shared except for the specific purposes of responding to your request for assistance.