

**GEORGIA SENIOR  
Farmers Market Nutrition Program (SFMNP)  
2025 Program Registration**



**Local Agency Use Only**

Card #: \_\_\_\_\_

<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>Date of Birth: (mm/dd/yyyy)</b>	<b>Mailing Address:</b>	
<b>City/State:</b>	<b>Zip Code:</b>	<b>County:</b>
<b>Phone Number: (     )     -</b>	<b>Email Address (optional):</b>	
<b>Ethnicity (Select One):</b> <input type="checkbox"/> <b>Hispanic or Latino</b> <input type="checkbox"/> <b>Not Hispanic or Latino</b>	<b>Race (Check all that apply):</b> <input type="checkbox"/> <b>American Indian or Alaska Native</b> <input type="checkbox"/> <b>Asian</b> <input type="checkbox"/> <b>Black or African American</b> <input type="checkbox"/> <b>Native Hawaiian or Other Pacific Islander</b> <input type="checkbox"/> <b>White</b>	
<p align="center"><b>Affidavit of Income</b></p> <p align="center">Please check the box that corresponds to your <u>total</u> household income*.  *2025 Federal Poverty Guidelines - 185% Threshold</p>		
<input type="checkbox"/> <b>\$28,953 or less annually for a one-person household</b>	<input type="checkbox"/> <b>\$39,128 or less annually for a two-person household</b>	<input type="checkbox"/> <b>\$49,303 or less annually for a three-person household</b>
<input type="checkbox"/> <b>\$59,478 or less annually for a four-person household</b>	<input type="checkbox"/> <b>\$69,653 or less annually for a five-person household</b>	<input type="checkbox"/> <b>\$79,828 or less annually for a six-person household</b>
<p align="center"><b>Proxy Designation (if applicable)</b></p> <p align="center">A person designated as a proxy must present acceptable personal identification along with the participant's completed application, and eligibility documents.</p>		
<b>Proxy Name:</b>	<b>Relationship to Participant:</b>	<b>Contact Number: (     )     -</b>
<p align="center"><b>Identification (ID) Presented (Check One):</b></p> <input type="checkbox"/> <b>State ID or Driver's License</b> <input type="checkbox"/> <b>Passport</b> <input type="checkbox"/> <b>Other: _____</b>		
<b>Proxy Signature:</b>		<b>Date:</b>

**Please turn the page to complete the registration form.**

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**Certification Statement**

I \_\_\_\_\_ (print name), the undersigned participant, certify that I am at least 60 years of age, or 55-59 years of age, deemed disabled, and currently living in a housing facility occupied primarily by older individuals where congregate nutrition services are provided; a resident of this service area; have not received SFMNP benefits at any other location this year; total household income requirements are met; and I have received training in the policies and procedures of the Georgia Senior Farmers Market Nutrition Program (SFMNP). I have been advised of my rights and obligations under the SFMNP. By signing this document, I agree that I understand the materials and know whom to contact if I have a question or complaint. 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.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The statement at the beginning of this form must be read by or read to all participants upon completion of the training in SFMNP procedures and prior to receipt of any SFMNP benefit cards. By signing below, I certify that this process has been conducted per Georgia Senior Farmers Market Nutrition Program guidelines.

Program Coordinator Signature: \_\_\_\_\_  
Senior Site Manager or Area Agency on Aging SFMNP Coordinator

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, audiotope, 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/ad-3027.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:

1. **mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[Program.Intake@usda.gov](mailto:Program.Intake@usda.gov)

This institution is an equal opportunity provider.