NJ DOH SFMNP APPLICATION AND INCOME SELF-DECLARATION

Office on Aging Site: Bergen County Division of Senior Services Application Date: _____ /_____/__2025__
Distribution Site:_____

Household Data:

Household Size: ____ Total Monthly Income: $_____ ☐ Check if Mailing Address Different

Address: _____City_____ Zip_____

Phone:_____ ☐Cell ☐Landline Email:_____

**If Homeless, please provide at least one form of identity:*
☐ Drivers License ☐ Birth Certificate ☐ Social Security Benefits Statement ☐ Other

Participant #1 - Head of Household :

Surname _____First Name_____ MI____

Date of Birth _____ Primary Language: _____ Monthly Income: $_____

***Ethnicity** (check one):*
☐ Hispanic
☐ Non-Hispanic

***Gender** (check one):*
☐ Male
☐ Female

***Race** (check all that apply):*
☐American Indian / Alaskan Native
☐Asian
☐Black / African American
☐Native Hawaiian / Pacific Islander
☐ White

***Proof of Identity** (check all that apply):*
☐Birth Certificate
☐Driver's License
☐Immigration Documents
☐Medical Card or Records
☐Other *(specify)*: _____

***Adjunctive Proof of Income*:**
☐ Medicaid
☐ SNAP (Food Stamp)
☐ CSFP
☐ SSI

Other Proof of Income:
☐ Affidavit - Self- Declaration: $_____per month
☐ Bank Statement ☐ Employers Letter ☐ Recent Pay Stub
☐ Unemployment Benefits ☐ W-2, prior year ☐ Social Security Disability
☐ Social Security/Retirement Statement ☐ Reliable 3rd Party Letter

Participant #2 – Spouse/ Domestic Partner:

Surname _____First Name_____ MI____

Date of Birth _____ Primary Language: _____ Monthly Income: $_____

***Ethnicity** (check one):*
☐ Hispanic
☐ Non-Hispanic

***Gender** (check one):*
☐ Male
☐ Female

***Race** (check all that apply):*
☐American Indian / Alaskan Native
☐Asian
☐Black / African American
☐Native Hawaiian / Pacific Islander
☐ White

***Proof of Identity** (check all that apply):*
☐Birth Certificate
☐Driver's License
☐Immigration Documents
☐Medical Card or Records
☐Other *(specify)*: _____

***Adjunctive Proof of Income*:**
☐ Medicaid
☐ SNAP (Food Stamp)
☐ CSFP
☐ SSI

Other Proof of Income:
☐ Affidavit - Self- Declaration: $_____per month
☐ Bank Statement ☐ Employers Letter ☐ Recent Pay Stub
☐ Unemployment Benefits ☐ W-2, prior year ☐ Social Security Disability
☐ Social Security/Retirement Statement ☐ Reliable 3rd Party Letter

Submit completed application in person at any of the SFMNP distribution sites (refer to SFMNP distribution schedule); or email to: seniors@bergencountynj.gov ;or mail to:
Bergen County Division of Senior Services, One Bergen County Plaza, 2nd Floor, Hackensack, NJ 07601, SFMNP
For more information call 201-336-7400 or visit www.co.bergen.nj.us/division-of-senior-services/nutrition .

To Be Completed by BC DSS Staff Member Only.

Household ID	**Approved by:**	**Date:**

NJ DOH SFMNP APPLICATION AND INCOME SELF-DECLARATION

SFMNP: RIGHTS AND OBLIGATIONS

1. I understand that I can receive SFMNP benefits from only (1) County or Municipal Office on Aging at a time.
2. I certify that I am not and will not attempt to enroll or obtain benefits from another County or Municipal Office on Aging.
3. I understand the SFMNP eligibility criteria, and I certify that all of the information that I have provided in this application is true and accurate.
4. I understand that the State, County or Municipality has the right to verify my information.
5. I understand that I can be disqualified from the SFMNP for failure to comply with these Rights and Obligations, and that may result in penalties or in disqualification from the SFMNP for the next year.
6. The County or Municipal Office on Aging will make health and nutrition services available to me, and I am encouraged to participate in these services.

Participation in the Senior Farmers' Market Nutrition Program is limited to those senior citizens who are 60 years and older and whose Household Income is equal to or less than the income poverty guidelines below.

Income Eligibility Guidelines (Effective from July 1, 2025 to June 30, 2026)

48 Contiguous States, D.C., Guam and Territorries

Family Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
☐ **1**	$ 28,953	$ 2,413	$ 1,207	$ 1,114	$557
☐ **2**	39,128	3,261	1,631	1,505	753
☐ **3**	49,303	4,109	2,055	1,897	949
☐ **4**	59,478	4,957	2,479	2,288	1,144
Each add'l member add	+$10,175	+$848	+$424	+$392	+$196

My signature indicates that I have reviewed the income guidelines by household. By signing this I attest that my income is at or below my household size, listed above. I also affirm that I live in Bergen County and I am at least 60 years of age. I understand that if any of these statements are found to be fraudulent, I will be subject to sanctions per the State Policies and Procedures.

By my signature, I certify that I have been advised of the Rights and Obligations and the Eligibility Criteria for the Senior Farmers Market Nutrition Program, and the information I have provided here is true and accurate.

_____	_____	___/___/ 2025
Name of Household Head (Print)	Signature	Date
_____	_____	___/___/2025
Name of Spouse (Print)	Signature	Date
_____	_____	___/___/ 2025
Alternate Authorized Representative (Print)	Signature	Date

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, etc.), 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: http://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:

1. **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

2. **fax:** (833) 256-1665 or (202) 690-7442; or

3. **email:** program.intake@usda.gov.

This institution is an equal opportunity provider.