NJ DOH SFMNP APPLICATION AND INCOME SELF-DECLARATION

Office on Aging Site: Bergen County Division of Senior Services   Application Date: _____ /_____/__2026__

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 .

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To Be Completed by BC DSS Staff Member Only.

	Date:	Local Agency Staff sign below:	Household ID
☐ **Approved** ☐ **Denied**			

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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, 2026 to June 30, 2027)

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

Family Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
☐ **1**	$ 29,526	$ 2,461	$ 1,231	$ 1,136	$568
☐ **2**	40,034	3,337	1,669	1,540	770
Each add'l member add	+$10,508	+$876	+$438	+$405	+$203

☐ I have reviewed the income guidelines by household. By signing this I attest that my income is at or below for 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.**

_____	_____	___/___/2026
Name of Household Head (Print)	Signature	Date
_____	_____	___/___/2026
Name of Spouse (Print)	Signature	Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

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