

New Jersey Department of Health
WIC Services
PO Box 364, Trenton, NJ 08625-0364

STATE USE ONLY	
Date Rec'd: _____	
Type of Application: <input type="checkbox"/> Initial	<input type="checkbox"/> Renewal
Vendor #: _____	
Contract Period: _____	
FY: _____	

**WIC AND SENIOR FARMERS' MARKET NUTRITION PROGRAM
APPLICATION FOR PARTICIPATION**

Important: All items must be completed. An incomplete application will be returned to you and will delay your authorization.

Name of Owner		
Permanent Mailing Address		County
City	State	Zip Code
Home Telephone Number	Cell Phone Number	Email Address

Do you currently have a bank account where ACH payments can be deposited? Yes No

Do you have a minimum of 5 acres in production of fruits and vegetables for human consumption?
 Yes (Complete **Section A**) No (Complete **Section B**)

SECTION A

Please attach proof of acreage: Farm Land Tax Assessment Lease Agreement Deed or Other

Is your farm enrolled in the Farmland Preservation Program? Yes No

Are you a member of a Farmers' Market Council? Yes No If Yes, identify: _____

Are you an organic farmer? Yes No If yes, do you sell conventional produce? Yes No

What provisions are available to assist persons with disabilities? _____

CROPS GROWN

List the types of crops you expect to grow (must grow at least 7 types):

Vegetables

Fruits

**WIC AND SENIOR FARMERS' MARKET NUTRITION PROGRAM
APPLICATION FOR PARTICIPATION, CONTINUED**

SECTION B

Select type of farm: _____ Size of farm: _____
 Please attach proof of soil and/or water testing: Soil Water _____
 Are you a member of a Farmers' Market Council? Yes No If Yes, identify: _____
 Are you an organic farmer? Yes No If yes, do you sell conventional produce? Yes No
 What provisions are available to assist persons with disabilities? _____

CROPS GROWN

List the types of crops you expect to grow (must grow at least 3 types):

Vegetables

Fruits

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FARMSTAND OR PERMANENT MARKET LOCATIONS

1	Market Name and Address		County				
			Type of Market <input type="checkbox"/> Permanent <input type="checkbox"/> Farmstand				
	Name of Person Responsible for FMNP Matters		Title		Market Telephone No.		
	Opening Date	Hours					
Closing Date	MON _____ AM to _____ PM	TUE _____ AM to _____ PM	WED _____ AM to _____ PM	THU _____ AM to _____ PM	FRI _____ AM to _____ PM	SAT _____ AM to _____ PM	SUN _____ AM to _____ PM
2	Market Name and Address		County				
			Type of Market <input type="checkbox"/> Permanent <input type="checkbox"/> Farmstand				
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**WIC AND SENIOR FARMERS' MARKET NUTRITION PROGRAM
APPLICATION FOR PARTICIPATION, CONTINUED**

TAILGATE FARMERS MARKETS											
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Are you interested in selling your produce at: <table border="0" style="width:100%; margin-left: 20px;"> <tr> <td style="width: 50%;">Local WIC Clinics? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 50%;">Senior Centers? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>		Local WIC Clinics? <input type="checkbox"/> Yes <input type="checkbox"/> No	Senior Centers? <input type="checkbox"/> Yes <input type="checkbox"/> No								
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Has any owner, manager or relative(s), or the business ever been charged, sanctioned or sentenced (suspension, disqualification, fine, etc.) for violations of the Supplemental Nutrition Assistance Program (SNAP) (Food Stamps)? <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> If Yes, date: _____											
Are you currently a Supplemental Nutrition Assistance Program (SNAP) (Food Stamps) Vendor? <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> If Yes, Authorization Number: _____ Date of Authorization: _____											

**WIC AND SENIOR FARMERS' MARKET NUTRITION PROGRAM
APPLICATION FOR PARTICIPATION, CONTINUED**

CERTIFICATION BY APPLICANT	
<p><i>To the best of my knowledge, all of the above information is true. I understand that any false statements made herein may result in the denial or withdrawal of my approval to participate in the WIC and Senior Farmers' Market Nutrition Program. I understand that if my application is approved for a Farmer/Grower Vendor Agreement, I will be bound by WIC and Senior FMNP Program regulations and policies including, but not limited to:</i></p> <ol style="list-style-type: none"> 1 attend vendor training; 2 train my employees in WIC and Senior FMNP and Cash-Value Benefits (CVB); 3 periodically be monitored; and 4 redeem WIC and Senior FMNP and Cash-Value Benefits (CVB) properly. <p><i>I understand that this is only a request for a vendor agreement. I understand that the WIC and Senior FMNP Program will consider the enclosed Selection Criteria when evaluating my application. I understand that if I am selected for Program participation, the New Jersey WIC and Senior FMNP and Cash-Value Benefits (CVB) Program does not guarantee a specific amount of business.</i></p>	
Name of Owner (Print)	Title
Signature of Owner or Authorized Agent	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), 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/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; or

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

(3) **email:** program.intake@usda.gov
This institution is an equal opportunity Provider.

STATE AGENCY USE ONLY	
Name of State Staff Reviewing Application (Print)	Title
Signature	Date
Name of Supervisor Reviewing Application (Print)	Title
Signature	Date