State of Illinois - Department of Human Services
WIC/Senior

FARMERS' MARKET NUTRITION PROGRAM: FARMER APPLICATION FOR PARTICIPATION

NAME: _____

MAILING ADDRESS: _____
STREET CITY STATE ZIP

TELEPHONE: _____ EMAIL: _____ FAX: _____

CONTACT PERSON: _____ FARMER ID#: _____
If different than name above.

BUSINESS NAME: _____

Taxpayer ID (SSN or FEIN): _____

Name of Primary Market/County where you will be accepting Farmer's Market Nutrition Program checks and other markets/counties you may attend:

Primary Market Name	in	County	Other Markets	in	County

List produce you grow and plan to sell at the markets:

I have read the training manual for the Illinois Farmers' Market Nutrition Program (FMNP) and request to be authorized to participate. I am the grower of fresh fruits and/or vegetables which I sell at the markets. I understand I will only be paid for checks accepted in designated counties, this season, based on dates listed. I understand that the Illinois Department of Human Services reserves the right to select participating FMNP Farmers. By signing this form I acknowledge that I understand the FMNP and the changes that have been implemented for the current season.

Signed: _____ Date: _____

Please mail completed application to:
Illinois Department of Human Services
Bureau of Family Nutrition
815/823 E. Monroe
Springfield, IL 62701
Attn: Farmers' Market Nutrition Program

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