



WIC Farmers' Market Nutrition Program Application

Return completed application by mail or email to:
Pinnacle Prevention 484 W. Chandler Blvd., Chandler, AZ 85225
Email: info@azfmnp.org

Scope of Program

- AZFMNP offers households participating in WIC the opportunity to purchase fresh, locally grown fruits and vegetables at participating farmers' markets in Arizona.
- WIC participants may receive one \$50 coupon booklet per household, limited to once per year. This program is first come first served based on the availability of funding
- To apply for WIC FMNP coupons, at least one member of your household must be an active WIC benefit recipient on the day that you apply. Eligible WIC FMNP recipient categories are: infants age 6 months or older, children age 1-5 years, and women and adults designated by WIC as pregnant, postpartum, or breastfeeding.
- You can review the rules and regulations online at www.AZFMNP.org or by phone 833-836-8253 ext. 4.

Proof of Current WIC Participation

Please request a benefit balance from your local office and send that in via email to info@azfmnp.org or mail to Pinnacle Prevention 484 W. Chandler Blvd., Chandler, AZ 85225.

Please indicate your WIC provider

- Adelante Healthcare WIC Apache County WIC Epiphany WIC Cochise County WIC Coconino County WIC El Rio Health WIC Gila County WIC Gila river Indian Community WIC Graham County WIC Greenlee County WIC Marana Healthcare WIC Maricopa County WIC Mariposa Community Health Center WIC Mohave County WIC Mountain Park health Center WIC Native Health WIC Navajo County WIC Pima County WIC Pinal County WIC Salt Ricer Pima-Maricopa Indian Community WIC Tohono O'odham Nation WIC Valle Del Sol WIC Wesley Community & Health Centers WIC Yavapai Apache Nation WIC Yavapai County WIC Yuma County WIC Clinic Not Listed Here Unsure

Applicant Details

Guardian first name: _____ Guardian Last name: _____

Phone number: _____ Ok to leave voicemail at this number?: Yes No

Email: _____ Preferred language: English Español Other: _____

Coupons for approved applications will be mailed to the address below by default. Check this box if you would like to OPT OUT of mailing. A program representative will contact you for alternatives to mailing if your application is approved.

Mailing Address (Arizona residents only)

Street address: _____ City: _____

State: Arizona Zip Code: _____ County of residence: _____

Household Information

In 2026, the AZFMNP is offering 1 \$50 coupon booklet *per household*. At the same time, it benefits the program to understand how many individuals are receiving WIC benefits within your household to assess the full demand for the farmers market program, and to identify and advocate for additional funding.

How many WIC recipients are currently in your household? (WIC recipients include: infants at least 6 months old, children 1-5 years, and pregnant, postpartum, or breastfeeding women/adults):

- 1 2 3 4 5 6 or more

First participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Second participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Third participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Fourth participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Fifth participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Sixth participating WIC client first and last name: _____ Date of birth: _____
Client Category: _____

Optional Questions (race & ethnicity)

What is your race? (Select all that apply):

- American Indian/Native Alaskan
- Black/African American
- Asian
- Native Hawaiian/Other Pacific Islander
- White, non-Hispanic
- White, Hispanic

Tribal Affiliation: _____

Ethnicity (select all that apply):

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

Participants' Rights and Responsibilities

I agree to abide by the rules of the Arizona Farmers' Market Nutrition Program. I have been advised of my rights and obligations under AZFMNP. 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. It is illegal to receive AZFMNP benefits from more than one state agency at a time. Standards for

eligibility and participation in AZFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the AZFMNP. This institution is an equal opportunity provider.

Applicant signature: _____ Date: _____