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www.nourishamerica.org

Program Application

DATE: _____

NAME OF ORGANIZATION: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____ - _____

Phone _____ **Fax** _____ **WEBSITE ADDRESS:** _____

ARE YOU A TAX-EXEMPT ORGANIZATION? YES NO Tax I.D. # _____

WHAT TYPE OF ORGANIZATION? School/After School Program Head Start/Healthy Start/WIC Faith-Based

Homeless Services City/County Services Public Health/Medical Clinic Other: _____

CLIENTS: Prenatal Infants Children Teens Families Seniors Veterans Disaster Relief

WHAT SERVICES DOES YOUR ORGANIZATION PROVIDE? _____

HEAD OF ORGANIZATION

NAME: _____ TITLE _____

PHONE: _____ EXT: _____ EMAIL: _____

OFFICIAL CONTACT PERSON FOR NOURISH AMERICA PROGRAMS:

NAME: _____ TITLE: _____

PHONE: _____ EXT: _____ FAX: _____

*EMAIL: _____

NOTE: In order for the program to remain cost effective, we require a viable, working email address for the contact person.

SHIPPING ADDRESS (FOR SUPPLEMENTS AND FOODS) Note: This must be a business address on a ground floor.

BUSINESS NAME: _____

ATTENTION: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____ - _____

Phone _____ **Fax** _____

Please fill out all pages =>

Storage Space: How many pallets can you receive of:

Shelf Stable Products _____ Refrigerated Products _____ Frozen Products _____

What is the total size of your storage capacity? _____

Lift Gate Needed Call Before Delivery

Products Requested: Please put a check in the box by the products you would like to receive:

<input type="checkbox"/>	1. Baby Food	<input type="checkbox"/>	17. Nuts, Nut-butters
<input type="checkbox"/>	2. Baked Goods	<input type="checkbox"/>	18. Oils
<input type="checkbox"/>	3. Baking mixes	<input type="checkbox"/>	19. Pasta
<input type="checkbox"/>	4. Cereal, ready to eat	<input type="checkbox"/>	20. Pet Food
<input type="checkbox"/>	5. Cleaning Products	<input type="checkbox"/>	21. Prepared Foods
<input type="checkbox"/>	6. Coffee	<input type="checkbox"/>	22. Seafood
<input type="checkbox"/>	7. Dental Hygiene Products	<input type="checkbox"/>	23. Skin Care Products
<input type="checkbox"/>	8. Drinks	<input type="checkbox"/>	24. Snacks
<input type="checkbox"/>	9. Eggs	<input type="checkbox"/>	25. Soy Products
<input type="checkbox"/>	10. Energy Drinks	<input type="checkbox"/>	26. Spices
<input type="checkbox"/>	11. First Aid Products	<input type="checkbox"/>	27. Nutritional Supplements/Multi-Vits
<input type="checkbox"/>	12. Fruit	<input type="checkbox"/>	28. Sweeteners
<input type="checkbox"/>	13. Gardening Supplies	<input type="checkbox"/>	29. Vegetables
<input type="checkbox"/>	14. Herbs	<input type="checkbox"/>	30. Tea
<input type="checkbox"/>	15. Juice	<input type="checkbox"/>	31. Whole Grains
<input type="checkbox"/>	16. Meat	<input type="checkbox"/>	32. Other:
<input type="checkbox"/>		<input type="checkbox"/>	

PLEASE LIST ALL YOUR SITES THAT WILL PARTICIPATE IN THE NOURISH AMERICA PROGRAM.

- If you need to list more than 4 sites – please make copies of this page.
- Give the number of participants at each location, as well as a GRAND TOTAL of all participants (at the bottom of the list).

1) SITE NAME: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

2) SITE NAME: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

3) SITE NAME: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

4) SITE NAME: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

TOTAL NUMBER OF CLIENTS (LISTED ABOVE) to participate in the program, each month: _____

Our organization requests approval as a partner distribution site for Nourish America’s programs. We understand that, as a condition of approval, we must participate in the Nourish America Annual Site Survey. We also understand and agree that if we choose to terminate our participation in the program (or are terminated) at any point, we are responsible for either distributing or returning any remaining product provided by Nourish America at our expense.

Our organization agrees to the above conditions of participation: **YES** **NO**

Organization Name: _____

* SIGNATURE: _____ DATE _____

NAME _____ TITLE _____

TITLE _____

* This form must be signed by an official, who is a legally authorized representative of the agency or organization (Exec. Director, President, Treasurer, etc.).

PLEASE FAX YOUR COMPLETED FORM TO NOURISH AMERICA AT (805) 715-9701. THANK YOU!