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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02622 (03/2023) | **STATE OF WISCONSIN** |
| **VENDOR / PARTICIPANT COMPLAINT**Wisconsin WIC and Senior Farmers’ Market Nutrition Program (FMNP) |
| The purpose of this form is to report to the local and/or state agency when the FMNP does not meet expectations. Complete the form with as much detail as possible. Some information may not apply; it is not required to provide all information on the form, only what is applicable.Persons seeking to file a program discrimination complaint may complete the [USDA Discrimination Complaint Form](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf), found online at <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, at any USDA office, or call 866‑632‑9992 to request the form. The Spanish form is available at [https://fns-prod.azureedge.us/sites/default/files/ resource-files/usda-program-discrimination-complaint-form-spanish.pdf](https://fns-prod.azureedge.us/sites/default/files/%20resource-files/usda-program-discrimination-complaint-form-spanish.pdf). Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800‑877‑8339. |
| 1. **Complaint**
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| Date of Incident | Time of Incident |
|       |       |
| Description of Complaint – Attach additional information if needed |
|       |
| Name of Person Filing Complaint | Phone Number of Person Filing Complaint |
|       |       |
| 1. **Applicant or Participant Information**
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| Name | Participant ID (for WIC only) |
|       |       |
| Address (Street, City, State, Zip Code) | Phone Number |
|       |       |
| Description of Applicant or Participant |
|       |
| 1. **Farmer Information**
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| Farmers’ Market or Farm/Roadside Stand (where incident occurred) |
|       |
| Farmer’s ID Number from FMNP Sign | Farmer’s Stall Number |
|       |       |
| Farmer’s Name and/or Business Name | Farmer’s Market or Farm/Roadside Stand Address (Street, City) |
|       |       |
| Description of Farmer |
|       |
| 1. **Checks Number(s):**
 |       |
| **I understand that I may be asked to participate in a hearing as a witness.** |
| **SIGNATURE** – Person Filing Complaint | Date Signed |
|  |  |
| **SIGNATURE** – FMNP Staff Recipient | Date Signed |
|  |  |
| **State or Local Office Use Only:** Investigation and solution of complaint: |

Complaint can be submitted to your local agency or dhswicfmnp@dhs.wi.gov.

This institution is an equal opportunity provider.