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CCC-884
(05-13-24)

U.S. DEPARTMENT OF AGRICULTURE
Commodity Credit Corporation

ORGANIC CERTIFICATION COST SHARE PROGRAM (OCCSP) (For 2020 and Subsequent Years)

1. County FSA Name and Address *(Including Zip Code)*

INSTRUCTIONS: Return this completed form to your County FSA Office.

NOTE: ***Privacy Act Statement:*** *The following statement is made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a - as amended). The authority for requesting the information identified on this form is the National Organic Program (7 C.F.R. Part 205), the Commodity Credit Corporation Charter Act (15 U.S.C. 714 et seq.), the Federal Crop Insurance Act (7 U.S.C. 1501 et seq. - as amended), the Organic Foods Production Act of 1990 (7 U.S.C. 6501 et seq. - as amended), the Farm Security and Rural Investment Act of 2002 (Pub. L. 107-171), the Agriculture Improvement Act of 2018 (Pub. L. 115-334), and the Further Continuing Appropriations and Other Extensions Act, 2024 (Pub. L. 118-22). The information will be used to determine the applicant's ability to participate in and receive benefits under the Organic Certification Cost Share Program. The information collected on this form may be disclosed to other Federal, State, Local government agencies, Tribal agencies, and nongovernmental entities that have been authorized access to the information by statute or regulation and/or as described in applicable Routine Uses identified in the System of Records Notice for USDA/FSA-2, Farm Records File (Automated). Providing the requested information is voluntary. However, failure to furnish the requested information will result in a determination that the applicant is unable to participate in and receive benefits under the Organic Certification Cost Share Program.*

Public Burden Statement (Paperwork Reduction Act): *According to the Paperwork Reduction Act of 1995 an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0560-0289. The time required to complete this information collection is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources gathering and maintaining the data needed, and completing and reviewing the collection of information. The provisions of criminal and civil fraud, privacy, and other statutes may be applicable to the information provided.*

PART A – APPLICANT INFORMATION

2. Applicant Name	3. Applicant's Address *(Including Zip Code)*	4. Have you recently participated in FSA programs? ☐ **YES** ☐ **NO** *(If **"NO"**, please fill out an AD-2047 and SF-3881)*	5. Applicant's Phone Number *(Including Area code)* 6. Email Address

PART B – CERTIFICATION INFORMATION

7. Name of Organic Certifier	8. Certification Number/Certifier Client ID	9. Current Date of Certification/Certificate Issued

10. Enter the program year (OCCSP program years are based on the **fiscal year in which expenses are paid**). See instructions for the specific dates covered by each program year. _____

11. Scope of Activity *(Check all that apply)* and Associated Costs:

☐ Crops $ _____ ☐ Livestock $ _____ ☐ State Organic Program Fees (CA Only) $ _____
☐ Wild Crops $ _____ ☐ Processing/Handling $ _____

12. Have you applied for cost share funds with your State for the program year in Item 10 and for the Scopes selected in Item 11? ☐ **YES** ☐ **NO**
*(If "**YES**", you will be ineligible for cost share benefits with FSA.)*

Non-Discrimination Statement: *In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. income*

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.

PART C – APPLICANT CERTIFICATION STATEMENT

Each applicant must submit a complete application to an FSA county office to be eligible to receive program benefits. A complete application includes form CCC–884, a copy of the applicant's organic certificate, itemized documentation of certification expenses paid by the applicant, and forms AD-2047 and SF-3881 if not previously filed with FSA. By signing this application, applicant:

1. Agrees to provide FSA any documentation required to determine eligibility and to verify and support all information provided, including applicant's organic certificate;

2. Understands the application may be disapproved if the applicant fails to provide a complete application or any information requested by FSA;

3. Agrees to comply with, and acknowledges the applicant is subject to, all provisions of OCCSP as published in the Notice of Funds Availability published in the Federal Register, and all applicable rules and regulations;

4. Understands that OCCSP payments are provided on a first come, first served basis until all available funds are obligated, and applications received after all funds are obligated will not be paid;

5. Acknowledges that if determined eligible and funding is available, the applicant's certification cost may be adjusted from the amount entered in Item 11 to reflect eligible allowable costs indicated by the documentation submitted to support the application.

I certify that:

1. The above information provided by me or my legal representative is true and correct.

2. I understand that failure to provide true and correct information may result in the invalidation of this application, a determination of noncompliance or ineligibility, or other remedies or sanctions.

3. I understand that I may not receive duplicate benefits for the same scope of activity and program year from both a State Agency and FSA. If it is determined that I have received duplicate benefits, I have no right to retain those payments.

13. Applicant's Signature *(By)*	14. Title/Relationship of the Individual Signing in the Representative Capacity	15. Date *(MM/DD/YYYY)*

PART D – CCC REPRESENTATIVE APPROVAL OR DISAPPROVAL

16A. CCC Representative's Signature *(or Designee)*	16B. Title of Representative or Designee	17. Action:	18. Date *(MM/DD/YYYY)*
		☐ APPROVED ☐ DISAPPROVED	