

<b>FSA-848</b> (09-27-10)	<b>U.S. DEPARTMENT OF AGRICULTURE</b> Farm Service Agency	1. ST. & CO. Code: 08 069 2. County Office Name, Address and Telephone Number LARIMER COUNTY FSA 2150 CENTRE AVE, BLDG A, STE 116 FORT COLLINS, CO 80526
<b>COST-SHARE REQUEST</b>		3. Application Number  4. Program Code EFRP
THIS REQUEST is submitted by the undersigned owners, operators, tenants, and/or producers (who individually may be referred to as "the Applicant"). By signing this form, the Applicant agrees to the following: 1) the Applicant is requesting cost-share assistance to perform a practice(s) designed to meet the objectives of the program referenced in Box 5; 2) the Applicant agrees that this practice(s) would not be performed without Federal cost-sharing; and, 3) if cost-sharing is approved for the practice(s) requested, the Applicant agrees to refund all or part of the funds paid to him/her, as determined by the Approving Official, if before expiration of the life span of the specified practice(s), the Applicant (a) destroys the approved practice(s), or (b) voluntarily relinquishes control of the title to, the land on which the approved practice(s) has been established, and the new owner and/or operator of the land does not agree in writing to properly maintain the practice(s) for the remainder of its life span. The Applicant further agrees that if he or she begins the practice(s) before receiving written approval, he or she may be denied cost-share funding. Further, the Applicant hereby authorizes a representative of USDA to have access to the practice site area(s). Further, the applicant understands that form FSA-848-1 is by reference incorporated herein. BY SIGNING THIS APPLICATION, THE APPLICANT ACKNOWLEDGES RECEIPT OF THE FOLLOWING FORMS: FSA-848 AND ANY ADDENDUM THERETO.		5. Contract ID (If applicable)
6. Description of Site and Practice Objectives		

EMERGENCY PROGRAMS ONLY		
7. Disaster Type: WILDFIRE  8. Crop(s) (Select): <input type="checkbox"/> Flowers or Bulbs <input type="checkbox"/> Vegetables or Fruits <input type="checkbox"/> Field Grown Ornamentals <input type="checkbox"/> Seed Crops <input type="checkbox"/> Grain or Row Crops <input type="checkbox"/> Other: <input type="checkbox"/> Orchards or Vineyards <input type="checkbox"/> Hay Forage or Pasture	9. Livestock(s) (Select and list amount with units):  <input type="checkbox"/> Cattle: <input type="checkbox"/> Buffalo/Beefalo: <input type="checkbox"/> Sheep: <input type="checkbox"/> Fish: <input type="checkbox"/> Goats: <input type="checkbox"/> Poultry: <input type="checkbox"/> Swine: <input type="checkbox"/> Horses, Mules or Donkeys: <input type="checkbox"/> Other animals raised exclusively for commercial food or fiber:	

10. PRACTICES REQUESTED									
A. Farm No.	B. Tract No.	C. Field No.	D. Practice Control No.	E. Practice Title	F. Practice Units	G. Practice Acres	H. Extent Requested	I. Requested Cost-Share	
J. Total Requested Cost-Share:									

11. APPLICANT'S REQUEST							
I (We) request cost-share assistance under the program to meet the objective(s) described above. The practice(s) on this request would not be performed without Federal cost-sharing. If cost-sharing is approved for the practice(s) requested, I agree to refund all or part of the funds paid to me as determined by the Approving Official, if before expiration of the specified practice life span(s) I, (a) destroy the approved practice(s), or (b) voluntarily relinquish control or title to, the land on which the approved practice has been established and the new owner and/or operator of the land does not agree in writing to properly maintain the practice(s) for the remainder of the life span(s). I understand that if I begin the practice before receiving written approval I may be denied funding.							
A. Applicant's Name, Address and Telephone Number	B. Percent Share 25%	C. Limited Resource <input type="checkbox"/> YES <input type="checkbox"/> NO	D. Beginning Farmer <input type="checkbox"/> YES <input type="checkbox"/> NO	E. Socially Disadvantaged <input type="checkbox"/> YES <input type="checkbox"/> NO	F. Signature (By)	G. Title/Relationship of the Individual If Signing in a Representative Capacity	H. Date (MM-DD-YYYY)
<b>NOTE:</b> The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a - as amended). The authority for requesting the information identified on this form is 7 CFR Part 701, 7 CFR Part 1410, and the Food, Conservation, and Energy Act of 2008 (Pub. L. 110-246). The information will be used to determine eligibility for program benefits. 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 of ineligibility for program benefits.							
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 0560-0082. The time required to complete this information collection is estimated to average 4 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. RETURN THIS COMPLETED FORM TO YOUR COUNTY FSA OFFICE.							
By signing this form, the Applicant acknowledges and understands that any false representation or claims are subject to civil and criminal penalties including, but not limited to those under 18 U.S.C. 1001.							

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