

## FARMER APPLICATION 2023 ARKANSAS SENIOR FARMERS' MARKET NUTRITION PROGRAM

Owner's Name (Checks will be made payable to this name)

Farm Name/Business Name (If Applicable)

Mailing Address (Payments will be mailed to this address)

City

State

Zip

County

Physical Address of farm where produce is grown

( )

Telephone Number

( )

FAX Number

E-MAIL

List the locations/days/hours where you plan to sell produce:

NAME: FARMERS MARKET FARM STAND ROAD STAND	LOCATION	HOURS SUN	HOURS MON	HOURS TUES	HOURS WED	HOURS THUR	HOURS FRI	HOURS SAT

List the Arkansas/locally grown fresh Fruits, Vegetables and/or Herbs you sell at this/these market(s) between May and October:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What percentage of the fresh Fruits, Vegetables and/or Herbs listed above is grown on your farm?

\_\_\_\_\_ %

List any other farmer(s) whose fruits, vegetables or herbs you bring to the market and **check the statement below:**

FARMER'S NAME	COUNTY	STATE

☐ I understand that if I purchase fruit, vegetables, or herbs outside of Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, or Washington counties or a bordering county, I cannot accept SFMNP coupons as payment.

List the names of any persons who will be acting for you at any meetings, selling for you at the market, etc. and CHECK the box of what they will be doing.

INDIVIDUAL'S NAME	SELLING	MEETINGS	OTHER

I have received and read the 2022 - 2023 Senior Farmers' Market Nutrition Program Farmer Agreement and agree to comply with all stated rules, regulations and policies. This Agreement is entered by the below signed Farmer and the Area Agency on Aging of Northwest Arkansas and shall be binding from the date signed below through the end of the 2022-2023 Senior Farmers' Market Nutrition Program. I certify that I am 18 years of age or older and reside in Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, or Washington counties, or in a bordering county.

\_\_\_\_\_  
Vendor Signature

\_\_\_\_\_  
Date

## FARMER AGREEMENT

I hereby attest that I agree to comply with all stated rules, regulation, and policies of the Senior Farmer's Market Nutrition Program (SFMNP) and the Area Agency on Aging of Northwest Arkansas and that I have no conflicts of interest with the Area Agency on Aging of Northwest Arkansas or the Arkansas Division of Aging and Adult Services.

### FARMER

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### LOCAL AGENCY

Area Agency on Aging of Northwest Arkansas

Signature: \_\_\_\_\_ Date: \_\_\_\_\_