

<p><b>FSA-18</b> (10-22-15)</p> <p style="text-align: center;"><b>U.S. DEPARTMENT OF AGRICULTURE</b> Farm Service Agency</p> <p style="text-align: center;"><b>APPLICANT'S AGREEMENT TO COMPLETE AN UNCOMPLETED PRACTICE</b></p>	<p>1A. COUNTY FSA NAME AND OFFICE ADDRESS <i>(Include Zip Code)</i></p>
	<p>1B. TELEPHONE NO. <i>(Include Area Code)</i></p>

<p>2. APPLICANT'S NAME</p>	<p>3. PROGRAM</p>	<p>4. FARM NO.</p>
<p>5. STATE WHERE FARM IS LOCATED</p>	<p>6. COUNTY WHERE FARM IS LOCATED</p>	<p>7. CONTRACT NO.</p>
		<p>8. CONTROL NO.</p>

**NOTE:** *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, the Commodity Credit Corporation Charter Act (15 U.S.C. 714 et seq.), the Food Security Act of 1985 (16 U.S.C. 3801 et seq.), and the Agricultural Act of 2014 (Pub. L. 113-79). The information will be used to document an agreement by an applicant to complete an uncompleted conservation practice. 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 to participate in and receive benefits under a conservation program.*

*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 10 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.*

**PART A - PRACTICE APPROVED ON FSA-848A**

9. NO.	10. DESCRIPTION	11. APPROVED EXTENT	12. COST-SHARES APPROVED

**PART B - COMPONENTS AS APPROVED ON FSA-848A**

13. CODE	14. DESCRIPTION	15. APPROVED EXTENT	16. RATE	17. COST-SHARES APPROVED

**PART C - COMPONENTS *(Identify each separately)***

18. The following component codes have been completed in accordance with specifications:

19. The following component codes have not been completed in accordance with specifications:

**PART D - APPLICANT'S CERTIFICATION**

*I request cost-share assistance for the completed components shown in Part C, Item 18 above. I agree to complete the components shown in Part C, Item 19, within the time prescribed by the County FSA committee, regardless of whether or not cost-share assistance is approved. I agree to refund any cost assistance paid to me under this practice, if I fail to complete it.*

20A. APPLICANT'S SIGNATURE	20B. Title/Relationship of the Individual if Signing in a Representative Capacity	20C. DATE (MM-DD-YYYY)
21A. APPROVED FOR COUNTY COMMITTEE BY		21B. DATE (MM-DD-YYYY)

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