

**GLACIAL HILLS FOOD CENTER APPLICATION**

*Start-up and Existing Businesses*

**CONTACT INFORMATION**

Business Name \_\_\_\_\_

Contact person \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Website \_\_\_\_\_

How did you find out about Glacial Hills Food Center?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever owned a business before? Yes No

If yes, please describe

\_\_\_\_\_

What actual product do you make? \_\_\_\_\_

Have you made or sold this product before? Yes No

If so, where and when?

\_\_\_\_\_

What kind of business do you operate or wish to operate?

\_\_\_\_\_

Please list general product ingredients and equipment you may utilize in your business:

\_\_\_\_\_

Do you plan to use locally grown or produced ingredients in your products? Yes No  
If so, please describe the role that local ingredients will play in your business and any local suppliers you plan to work with.

Do you plan to emphasize the use of healthy ingredients in your products? Yes No  
If so, please describe these ingredients and how they contribute to a healthier product.

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Is a written business plan available for review? Yes No

Does your business have adequate financing? Yes No

Who is your target market?

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Anticipated number of hours of kitchen usage needed per week or month:

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Please check any areas of business support you need so we can help you locate sources of information and counseling, plan workshops, etc:

Business Plan Writing \_\_\_\_\_  
Accounting/Bookkeeping \_\_\_\_\_  
Distribution/Marketing \_\_\_\_\_  
Capital Access \_\_\_\_\_  
Product Formulation Assistance \_\_\_\_\_  
Fax/Color Copier \_\_\_\_\_  
Labeling Design \_\_\_\_\_  
Nutritional Analysis \_\_\_\_\_  
Recipe Conversion \_\_\_\_\_  
Other services: (please list)