CO-MO CARES TRUST, INC.

PO BOX 220
TIPTON, MO 65081
(660) 433-5521
Attn: Michele Stufflebean, "Operation Round Up"

Application For Donation For Individual and/or Family

Note: ***Please type or print clearly with dark ink.*** It is extremely important that you completely fill out this application. Provide all information requested, including addresses, telephone numbers, contact person, etc. **INCOMPLETE APPLICATIONS WILL AUTOMATICALLY BE DENIED ASSISTANCE.**

If you are applying for scholarship assistance, you need to fill out a different form. In that case, contact Michele Stufflebean at the above phone number.

1. Name: ____
Last First Middle

Reason for request for donation: [Please be specific in the amount of request and how it would be used]

2. Names and Income of Household Members:

List Members of Household, including children **list ages of children only**	Gross MONTHLY Earnings (Before Deductions) Job 1	Job 2	MONTHLY Welfare Payments, Child Support, Alimony	MONTHLY Payments from Pensions, Retirement, Social Security	Any Other MONTHLY Income
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

Any other sources of income not included above:

$ ____________ Source: ______________________________

3. Address: ____

Street /Post Office Box

City or Town | State | Zip Code | County

4. Phone Number: ____

Home | Work

5. Are you currently employed? Yes __ No__

If not, please explain why:

6. Employment History for person's listed in No. 1 and No. 2 (on page 1):
(List present or most recent positions first)

No. 1

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

No. 2

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

Name of Employer | Address

Supervisor | Phone Number | Dates of Employment | Salary/Wage

7. Explain the circumstances that have prompted your need for assistance:

8. What other social service agencies (Family Services, etc.) have you contacted? (include name and phone number of contact person):

9. Is individual or family receiving any other form of assistance or aid for stated request (donations, insurance, etc.)? Yes __ No __

   If yes, please list:

PLEASE COMPLETE ATTACHED FINANCIAL CONDITION STATEMENT

10. Statement of Financial Condition as of: ____________, 20____

ASSETS

Amounts

Cash

(list checking & savings account balances)

Banking Institution	Checking Account No.	$
Banking Institution	Savings Account No.	$
Banking Institution	Account No.	$

Real Estate

(list real property that you own, ie: house, mobile home, acreage)

Partial or Wholly Owned	County	$ Market Value
Partial or Wholly Owned	County	$ Market Value
Partial or Wholly Owned	County	$ Market Value

Other Receivables (State Type: Personal Property, Loan Receivable, Auto, Life Insurance (Cash Value) Other Assets. (Include description, account number, etc.)

Type	Description	Account Number	$ Value
Type	Description	Account Number	$ Value
Type	Description	Account Number	$ Value
Type	Description	Account Number	$ Value
Type	Description	Account Number	$ Value
Type	Description	Account Number	$ Value

TOTAL ASSETS **$** ________

LIABILITIES - list all outstanding debts/loans that you are responsible for

Amounts

Notes Payable
(list car loans, student loans, credit card debts, etc.)

______________________________ $______
Lender's Name

____
Address

______________________________ $______
Lender's Name

____
Address

______________________________ $______
Lender's Name

____
Address

Mortgage
(ie: house or property)

______________________________ $______
Mortgagor's Name

____
Address

______________________________ $______
Mortgagor's Name

____
Address

Other Debt
(State Type: Taxes, Bills Outstanding, Other)

______________________________ $______
Type

______________________________ $______
Type

______________________________ $______
Type

______________________________ $______
Type

TOTAL LIABILITIES **$**______

MONTHLY EXPENSES

		Amounts
Housing	Mortgage ________ Rent ________	$ ________
Food		$ ________
Utilities	Electricity	$ ________
	Gas	$ ________
	Telephone	$ ________
Transportation	Automobile Payments	$ ________
	Gasoline	$ ________
Insurance	Medical	$ ________
	Life	$ ________
	Automobile	$ ________
	House	$ ________
Medical	Doctors	$ ________
	Hospital	$ ________
	Medication	$ ________
Charge Accounts	________	$ ________
(Specify)	________	$ ________
	________	$ ________
	________	$ ________
Loans	________	$ ________
(Specify)	________	$ ________
	________	$ ________
Taxes	________	$ ________
(Specify)	________	$ ________
	________	$ ________
	________	$ ________
Other Expenses	________	$ ________
(Specify)	________	$ ________
	________	$ ________
	MONTHLY EXPENSES	$ ________

SOURCES OF MONTHLY INCOME

	Amounts
Total Gross Earnings for Household	$ ________
Bonus, Tips & Commission	$ ________
Social Security Benefits	$ ________
Farm Income	$ ________
Welfare (AFDC)	$ ________
Food Stamps	$ ________
Alimony	$ ________
Child Support	$ ________
Other: (list all other sources of income)	
____	$ ________
____	$ ________
TOTAL MONTHLY INCOME	$ ________

Please list three references (only one family member may be listed as a reference). Directors or employees of Co-Mo Electric Cooperative, Inc. or the Co-Mo Cares Trust, Inc. may not be used as a reference.

____

Name | Phone Number - Day | Phone Number - Evening

____

Address | City | State | Zip Code

____

Name | Phone Number - Day | Phone Number - Evening

____

Address | City | State | Zip Code

____

Name | Phone Number - Day | Phone Number - Evening

____

Address | City | State | Zip Code

The information contained in this statement is for the purpose of obtaining funding from the Co-Mo Cares Trust, Inc. on behalf of the undersigned. Each undersigned understands that the information provided herein is used in deciding to grant funding, and each undersigned represents and warrants that the information provided is true and complete and that the Co-Mo Cares Trust, Inc. may consider this statement as continuing to be true and correct until a written notice of change is provided. The Co-Mo Cares Trust, Inc. is authorized to make all inquiries it deems necessary to verify the accuracy of the statement made herein.

The undersigned hereby authorizes any employer, insurer, governmental department or agency, hospital, physician, medical attendant, nurse, technician, practitioner, attorney, or other person having in their possession records, opinions, reports, x-rays, photostatic copies, abstracts or excerpts of any records, or any other information or document required to establish the validity of, or to provide further information concerning the undersigned's application for funding assistance, to furnish the same to the Board of Trustees of Co-Mo Cares Trust, Inc., and the undersigned hereby waives any exclusive privilege thereto in favor of said Board of Trustees.

The undersigned further authorizes a photocopy of this authorization to be considered as valid and binding as the original thereof and understands that any information provided to said Board of Trustees is for the official use in the deliberations of said Board of Trustees and will be kept confidential in all respects unless otherwise expressly authorized by the undersigned.

This Authorization expressly releases all persons, firms, corporations, and other entities providing information in accordance herewith from any liability on account of true and accurate disclosure hereunder.

______________________________	______________________________
NAME OF APPLICANT/RECIPIENT - PRINT	NAME OF SPOUSE - PRINT
______________________________	______________________________
SIGNATURE OF APPLICANT/RECIPIENT	SIGNATURE OF SPOUSE
	______________________________
	DATE

*Applicant(s) will be notified in writing as to the outcome of their request after the monthly Trust Board Meeting.