CO-MO CARES TRUST, INC.

PO BOX 220
TIPTON, MO 65081
(660) 433-5521
Attn: Montana Dorsey, "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? _____ 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

_____
Address

_____ $_____
Lender's Name Address

_____
Address

_____ $_____
Lender's Name Address

_____
Address

Mortgage

(ie: house or property)

_____ $_____
Mortgagor's Name Address

_____
Address

_____ $_____
Mortgagor's Name Address

_____
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.