

CO-MO CARES TRUST, INC.

PO BOX 220
TIPTON, MO 65081
(660) 433-5521

Attn: Michele Jensen, "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:

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

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

Amount:

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.