APPLICATION

FARMERS' ELECTRIC AREA YOUTH BENEFIT FUND

APPLICATION #: ____________________________ Received: _______________________________

Section 1

1. Name of Child: ____
   (last) (first) (middle)

2. Residence of Child: ____
   (street address) (city) (county) (zip)

   Length of residency at this location:________________________________

3. Age:__________ Sex: __________ Birth Date: ______________________________
   (xx/xx/xx)

4. Name of Father: ______________________________________ Age: __________
   (first) (middle) (last)

   Address: ____
   (street address) (city) (state) (zip)

   Phone Number:__________________________

   Marital Status (circle one): single married separated divorced or widowed

5. Name of Mother: ______________________________________ Age: __________
   (first) (middle) (last)

   Address: ____
   (street address) (city) (state) (zip)

   Phone Number: __________________________

   Marital Status (circle one): single married separated divorced or widowed

6. Name of Legal Guardian if different from above:______________________ Age: ________
   (first) (middle) (last)

   Address: ____
   (street address) (city) (state) (zip)

   Phone Number: __________________________

   Marital Status (circle one): single married separated divorced or widowed

7. Nature of illness of injury: ____

   Date of illness or injury: ____

8. If child is in a hospital provide name and address of hospital: ____________________

   ____

If child is presently under doctor's care, please have the doctor complete Section III of this form. If child is not presently under doctor's care, give name, address and telephone number of physician who last treated the child:

____

(physician's name)

Address: ____

(street) (city/state/zip) (phone)

Section II

THIS SECTION TO BE COMPLETED BY APPLICANT'S PARENTS OR LEGAL GUARDIAN.

1. Number of dependent children _______ Ages: ____

		Father/Legal Guardian	Mother
2.	Name of Employer:	________________________	________________________
3.	Address of Employer:	________________________	________________________
		________________________	________________________
4.	Date Employed:	________________________	________________________
5.	Exact kind of work:	________________________	________________________
	(check one)	Full Time _____ Part Time_____	Full Time _____ Part Time_____

6. Family taxable income according to last year's tax return:

_____ 0 - $15,000
_____ $15,001 - $25,000
_____ $25,001 - $45,000
_____ $45,001 – up

7.	Previous Employer:	________________________	________________________
8.	How long employed:	________________________	________________________
9.	Previous Salary:	$________________________	$________________________

10. Do you rent your principal residence? ______ Monthly rental payment $___________________
11. Do you own your own home? ______ Monthly mortgage payment $________________
12. Is your child covered by medical or hospitalization insurance? Yes _____ No _____
13. If there is coverage by both parents' employers, indicate both companies:

 a. Father's insurance company: Name of Company____
 Policy Number: ____

 b. Mother's insurance company: Name of Company____
 Policy Number: ____

14. Do you presently owe for any medical treatment for this child not covered by insurance? *

Yes ______ No ______

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

Indicate Amount: $_____________

To Whom: ____

Address: ____

15. Have there been any other medical bills in the family recently? Yes_____No_____

For Whom:____Amount:_____________________

To Whom:____

Address:____

For Whom:____Amount:_____________________

To Whom:____

Address:____

15. (Cont.) Have there been any other medical bills in the family recently? Yes_____No_____

For Whom:____Amount:_______________________

To Whom:____

Address:____

For Whom:____Amount:_______________________

To Whom:____

Address:____

For Whom:____Amount:_______________________

To Whom:____

Address:____

For Whom:____Amount:_______________________

To Whom:____

Address:____

For Whom:____Amount:_______________________

To Whom:____

Address:____

16. Have you had other expenses, other than medical, pertaining to care for the child?

Please itemize (such as mileage, lodging, meals, etc. Use additional paper if necessary.)

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17. Other efforts being made to raise necessary funds not covered by insurance:

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18. Name of Fund established for child: _______________________________

Mailing address of Fund: _______________________________

I hereby certify that the foregoing statements are true and correct to the best of my knowledge.

_______________	_______________	_______________
Signature of Father	Signature of Mother	Signature of Legal Guardian (if other than parents)

*** If requesting assistance with the payment of medical bills, please send a copy of the current statement from the provider(s).**

Information contained in this application shall remain confidential. Return completed application to:

Farmers' Electric Area Youth Benefit Fund
Attn: Jennie Tipton
201 W Business 36
Chillicothe MO 64601

PHYSICIAN'S CERTIFICATE

Date: ________________

Section III

1. Patient's Name ______________________________

2. Describe injury or illness: ______________________________

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3. Remarks and recommendations: ______________________________

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4. Physician's Name (please print) ______________________________

5. Physician's Address ______________________________

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6. ______________________________

(Signature of Physician)

ACTION OF BOARD OF DIRECTORS

Date: ________________ Approved: ________________ Disapproved:________________

Amount of Contribution: $______________________________

Reason if Disapproved: ______________________________

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Signature ______________________________

President of Board