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 (check 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 (check 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 (check 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

		Father/Legal Guardian	Mother
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: Laura Cary
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