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:_____

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.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: Lacey Capps
201 W Business 36
Chillicothe MO 64601

PHYSICIAN'S CERTIFICATE

Date: _____

Section III

1. Patient's Name _____

2. Describe injury or illness: _____

_____

_____

_____

_____

3. Remarks and recommendations: _____

_____

_____

_____

_____

4. Physician's Name (please print) _____

5. Physician's Address _____

_____

6. _____
(Signature of Physician)

ACTION OF BOARD OF DIRECTORS

Date: _____ Approved: _____ Disapproved:_____

Amount of Contribution: $_____

Reason if Disapproved: _____

_____

_____

_____

Signature _____

President of Board