Intercounty Charitable and Educational Foundation

PO Box 209
Licking, Missouri 65542
toll-free 866-621-3679, fax 573-674-2985
Attn: *Operation Round Up* Coordinator

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 address, telephone numbers, contact person, etc. **Incomplete applications will automatically be denied assistance. Failure to disclose completion of this application by someone other than the applicant will also result in automatic denial.**

1. Name: _____

   Last | First | Middle | Marital Status

2. Reason for request for donation (please be specific in the amount of request and how it would be used).

   Amount $ _____

   Intended use of requested funds: _____

   _____

   _____

3. List all household members and dependents (**include ages**):

   _____
   Name | Relationship | Age

   _____
   Name | Relationship | Age

   _____
   Name | Relationship | Age

   _____
   Name | Relationship | Age

   _____
   Name | Relationship | Age

4. Physical address of residence: _____

   _____
   City/Town | State | Zip Code | County | Years at this residence

   Mailing address (if different): _____

5. E-mail address: _____

6. Phone Numbers: _____
   Home | Cell

   _____
   Work | Message

7. Are you currently employed? _____ If not, please explain why? _____

_____

If disabled, describe your disability: _____

_____ Years disabled: _____

8. Employment history for applicant (list present or most recent position first):
Use separate sheet if required to supply information on more than two employable individuals living in the household.

Name of employer	Address		Job Title
Supervisor	Phone no.	Dates of employment	Salary/Wage
Name of employer	Address		Job Title
Supervisor	Phone no.	Dates of employment	Salary/Wage

Employment history for spouse or other household member (list present or most recent position first):

Name of employer	Address		Job Title
Supervisor	Phone no.	Dates of employment	Salary/Wage
Name of employer	Address		Job Title
Supervisor	Phone no.	Dates of employment	Salary/Wage

9. Type of medical coverage (please circle): Private Insurance Medicaid Medicare Self-Pay

10. Explain the circumstances that have prompted your need for assistance. Attach at least two written bids, quotes, or estimates if request is for assistance with repair or replacement of items.

_____

_____

_____

_____

_____

11. List all other social service agencies/organizations (Family Services, Ozark Independent Living, MOCA, Food Pantry, etc.) you have contacted in the last six months (list any amounts received).

Name	Contact Person	Phone	Amount Received
Name	Contact Person	Phone	Amount Received
Name	Contact Person	Phone	Amount Received

Use the back of the form if needed for additional agencies/organizations. You should include all agencies and organizations from which you have requested help, even if you haven't yet received the assistance.

12. **ASSETS**--What you own

Amounts

Cash

_____ $ _____
Banking Institution Checking Acct. No.

_____ $ _____
Banking Institution Savings Acct. No.

_____ $ _____
Banking Institution Acct. No.

Real Estate (Include all "physical property," such as house, mobile home, land)

_____ $ _____
Type County Value

_____ $ _____
Type County Value

All Other Assets (State type: vehicles, personal property, cash value of life insurance, etc.)

_____ $ _____
Type Value

_____ $ _____
Type Value

_____ $ _____
Type Value

TOTAL VALUE OF ASSETS **$**_____

13. **SOURCES OF MONTHLY INCOME**

	SELF	SPOUSE	OTHER
Earnings for household--salaries, self employment, etc.	$	$	$
Bonus, tips, and commission	$	$	$
Social Security benefits--to include SSI and disability	$	$	$
Public Assistance Compensation	$	$	$
Food Stamps	$	$	$
Child Support	$	$	$
Unemployment	$	$	$
Other--list all other sources of income			
_____	$	$	$
_____	$	$	$
TOTAL MONTHLY INCOME	**$**	**$**	**$**

14. **MONTHLY EXPENSES**--Identify amounts you pay each month

		Avg. Monthly Amount	Any Amount Past Due
Housing	Mortgage_____Rent_____	$	$
If renting, please list landlord's name, address, and phone number:_____			
What amount does HUD pay?_____			
Food		$	$
Utilities			
	Electricity	$	$
	Gas/Propane	$	$
	Telephone	$	$
	Cell Phone	$	$
	Water/Sewer	$	$
	Trash	$	$
Transportation			
	Vehicle Payment	$	$
	Gasoline	$	$
Insurance			
	Medical	$	$
	Life	$	$
	Motor Vehicle	$	$
	Homeowner's/Rental	$	$
Medical			
	Doctors	$	$
	Hospital	$	$
	Medication	$	$
Charge Accounts (specify: MC, Visa, JC Penny, etc.)			
	_____	$	$
	_____	$	$
	_____	$	$
	_____	$	$
Loans (specify)			
	_____	$	$
	_____	$	$
Taxes (specify)			
	_____	$	$
	_____	$	$
Other Expenses (payments you make such as Internet, cable/ satellite TV, daycare, child support, alimony, etc.)			
	_____	$	$
	_____	$	$
	_____	$	$
	_____	$	$
	_____	$	$
TOTAL MONTHLY EXPENSES		$_____	

15. **LIABILITIES**--Amounts you owe

Notes Payable (car or student loans, credit card debts, personal loans, etc) **Amount Owed**

_____ $_____
Lender's Name Lender's Address

_____ $_____
Lender's Name Lender's Address

_____ $_____
Lender's Name Lender's Address

Mortgage (house or property)

_____ $_____
Lender's Name Lender's Address Loan No.

_____ $_____
Lender's Name Lender's Address Loan No.

All Other Debts (State type: personal property and real estate taxes, outstanding bills, etc.)

_____ $_____
Type

_____ $_____
Type

_____ $_____
Type

TOTAL AMOUNT OWED **$_____**

16. **REFERENCES**

Please list three references (May not be a director or employee of Intercounty Electric Cooperative or the Intercounty Charitable and Educational Foundation).

_____
Name Phone Relationship to Applicant

_____
Address City State Zip Code

_____
Name Phone Relationship to Applicant

_____
Address City State Zip Code

_____
Name Phone Relationship to Applicant

_____
Address City State Zip Code

The information contained in this statement is for the purpose of obtaining funding from the Intercounty Charitable and Education Foundation 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 Intercounty Charitable and Educational Foundation may consider this statement as continuing to be true and correct until a written notice of a change is provided. **The Intercounty Charitable and Educational Foundation is authorized to make all inquiries they deem necessary to verify the accuracy of the statement made herein.**

Applicant's Social Security No.	Date of Birth	Signature of Applicant
Spouse's Social Security No.	Date of Birth	Signature of Spouse
		Date

If this application was completed by someone other than the applicant, third party preparer must sign, print, and date below.

Preparer's Printed Name	Preparer's Signature	Date