



If the answer to question #4 is yes, skip to #6 **unless** there have been significant changes in your income.

\*You must complete question 5 if you are applying for assistance through Owatonna Clinic-Mayo Health Systems.

5. Indicate source and amount of current income before deductions, such as taxes and social security. If you receive more than one check from any of these sources, please indicate the total amount received.

	Head of Household Weekly	Head of Household Monthly	Other (explain) Weekly	Other (explain) Monthly
<b>Wages/Salary</b>				
<b>Social Security</b>				
<b>Public Assistance(Welfare)</b>				
<b>Unemployment</b>				
<b>Child Support(Alimony)</b>				
<b>Pension or Retirement</b>				
<b>Other</b>				
<b>TOTAL FAMILY INCOME</b>				

**THIS IS CONFIDENTIAL INFORMATION. Your signature allows us to communicate on your behalf with care providers from which you have requested assistance. Refusing permission to communicate with care providers will limit CRF's ability to assist you or your family.**

**Agencies you are allowing CRF to communicate with are the following:**

\_\_\_\_\_.

You will be informed as soon as possible as to whether or not you can receive assistance from the CRF.

6. \_\_\_\_\_  
Date form completed Signature of Parent/Guardian

\*\*\*\*\*

Please return form to: Susanne Schroeder, Children's Remedial Fund  
Owatonna Middle School  
500 15th Street NE  
Owatonna, MN 55060

*(for office use only)*

\_\_\_\_\_ \_\_\_\_\_  
*Date eligibility verified/ phone* *Signature of person verifying information*

*Date reviewed* \_\_\_\_\_ *Application approved* \_\_\_\_\_ *Application denied* \_\_\_\_\_

*Notes:* \_\_\_\_\_