



6296 Rivers Ave., Suite 300
North Charleston, SC 29406
Tele: (843) 554-6222 Fax: (843) 747-7222
www.carolinachildren.org

GRANT APPLICATION

The monies of the CAROLINA CHILDREN'S CHARITY are intended to support patient care, medical services and related activities.

1. NAME OF CHILD _____
LAST FIRST MIDDLE

Male

Female

AGE _____ DATE OF BIRTH _____ NICKNAME _____

2. PARENT/GUARDIAN 1: _____
LAST FIRST MIDDLE

STREET CITY ZIP COUNTY

TELEPHONE: _____
HOME WORK MOBILE FAX E-MAIL

EMPLOYER _____ TITLE _____

WORK ADDRESS _____
STREET CITY ZIP

3. PARENT/GUARDIAN 2: _____
LAST FIRST MIDDLE

STREET CITY ZIP COUNTY

TELEPHONE: _____
HOME WORK MOBILE FAX E-MAIL

EMPLOYER _____ TITLE _____

WORK ADDRESS _____
STREET CITY ZIP

4. NUMBER & AGES OF OTHER DEPENDENT CHILDREN: _____

5. CASEWORKER/SERVICE
COORDINATOR/EI _____

AGENCY _____ PHONE _____

6. DIAGNOSIS OF DISABILITY:

7. OUTLINE OF FUNDING REQUESTED: Please be specific & include all costs. \$ _____

a. item or service: _____

b. supplier _____

c. address of supplier _____

d. phone number _____

Please attach any information available (i.e., brochure, picture)

8. DOCTORS INVOLVED IN CHILD'S TREATMENT

NAME: _____ PHONE _____

ADDRESS: _____

NAME: _____ PHONE _____

ADDRESS: _____

9. MEDICAL INSURANCE:

a. CARRIER: _____ MEMBER ID# _____

CONTACT PERSON _____ PHONE _____

b. MEDICAID ID# _____

10. NAMES OF OTHER AGENCIES OR SERVICES CONTACTED FOR FUNDING:

DATE CONTACTED AMOUNT RECEIVED

a. DEPT OF DISABILITIES AND SPECIAL NEEDS (DDSN)) _____

b. CHILDREN'S REHABILITATION SERVICES (CRS) _____

c. SUPPLEMENTAL SECURITY INCOME (SSI) _____

d. OTHERS: _____

11. PLEASE LIST ANY ADDITIONAL INFORMATION THAT COULD HELP IN PROCESSING YOUR REQUEST.
(Example: All medical costs such as medication, etc.) You may use a separate sheet if necessary.

12. DOCTOR'S LETTER: We must have a letter from your child's physician which states the child's diagnosis and confirms that your request is medically necessary/beneficial for your child.

13. You DO have my permission to send me information by fax _____ (initial)
You DO NOT have my permission to send me information by fax _____ (initial)

14. You DO have my permission to send me information by e-mail _____ (initial).
You DO NOT have my permission to send me information by e-mail _____ (initial).

15. You DO have my permission to use my and/or my child's name in promotion of Carolina Children's Charity and its fundraising activities _____ (initial).
You DO NOT have my permission to use my and/or my child's name in promotion of Carolina Children's Charity and its fundraising activities _____ (initial).

16. You DO have my permission to use my and/or my child's photographic or video image in promotion of Carolina Children's Charity and its fundraising activities _____ (initial).
You DO NOT have my permission to use my and/or my child's photographic or video image in promotion of Carolina Children's Charity and its fundraising activities _____ (initial).

I understand it may be necessary to appear before the Carolina Children's Charity Grants Committee to supply further information and/or have a home evaluation. I am 18 or older and have the authority to submit and sign this application.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____
Relationship to child: Parent Grandparent Foster Parent Other _____

This application cannot be considered until this form is completed, signed, and all supporting documents (including doctor's letter) are received.

CONFIDENTIAL

(for use by Carolina Children's Charity only)

**Personal Statement of Income and Financial Status
of All Persons Contributing to the Household**

ASSETS

MONTHLY EXPENSES

Checking Acct Balance	\$ _____	Rent or house payment	\$ _____
Savings Acct Balance	\$ _____	Electric/Gas/Water/Phone/Cable	\$ _____
Real Estate		Car Payment(s) & Insurance	\$ _____
Home	\$ _____	Childcare	\$ _____
Other	\$ _____	Groceries	\$ _____
Car(s)	\$ _____	Clothing	\$ _____
Personal Property	\$ _____	Credit Card(s)	\$ _____
Other _____	\$ _____	All other expenses	\$ _____
		TOTAL EXPENSES	\$ _____
TOTAL ASSETS			\$ _____

MEDICAL BILLS DUE:	Physician	_____	\$ _____
	Hospital	_____	\$ _____

COMBINED SOURCES OF INCOME: (Previous year's federal tax return must be provided if grant request is above \$300.00.)

	Monthly		Annual/Yearly
Salary	\$ _____	X 12 =	\$ _____
Bonuses & Commissions	\$ _____	X 12 =	\$ _____
Alimony/Child Support	\$ _____	X 12 =	\$ _____
Real Estate Income	\$ _____	X 12 =	\$ _____
Other [including Supplemental Security Income (SSI), retirement, etc.]	\$ _____	X 12 =	\$ _____
TOTAL INCOME	\$ _____		\$ _____

The above information is freely given to process this grant request.

Signature of Parent/Guardian _____ **Date** _____