1064 Gardner Road, Suite 112B
Charleston, SC 29407
Tele: (843) 769-7555 Fax: (843) 769-7553
www.carolinachildren.org

GRANT APPLICATION

The monies of the CAROLINA CHILDREN'S CHARITY are intended to support patient care, medical services and related activities. All Carolina Children's Charity grant funding is paid directly to the provider.

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. NAMES & AGES OF OTHER CHILDREN IN YOUR HOME: _____

5. DIAGNOSIS OF DISABILITY:

_____

_____

_____

6. OUTLINE OF FUNDING REQUESTED: Please be specific & include all costs. $_____
   1. item or service:_____
   2. supplier_____
   3. address of supplier_____
   4. phone number_____

7. Does your child attend school? Check yes____ no____ Name of school_____

8. Does your child have access to this item or service in school? Check yes_____ no_____

9. Will this item be used at home or at school? Please explain: _____

_____

10. Please explain why additional services are needed and/or why the item is needed in the home:

_____

_____

_____

11. Please attach any information available (i.e., brochure, picture) to support this request.

11. DOCTORS INVOLVED IN CHILD'S TREATMENT

DOCTOR'S NAME_____NAME OF PRACTICE_____

ADDRESS: _____PHONE_____

DOCTOR'S NAME_____NAME OF PRACTICE_____

ADDRESS: _____PHONE_____

12. MEDICAL INSURANCE:

a. CARRIER: _____MEMBER ID#_____

CONTACT PERSON _____PHONE_____

b. MEDICAID ID#_____

c. Is the item or service being requested covered by your insurance? Check yes____ no____

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

	DATE CONTACTED	AMOUNT RECEIVED
a. DISABILITIES Board of Charleston, Dorchester, Colleton or Berkeley Citizens	_____	_____
b. CHILDREN'S REHABILITATION SERVICES (CRS)	_____	_____
c. SUPPLEMENTAL SECURITY INCOME (SSI)	_____	_____
d. SCHOOL FOR THE DEAF and BLIND	_____	_____
e. PRIVATE PROVIDER of EARLY INTERVENTION OR SERVICE COORDINATION	_____	_____

14. DOES YOUR CHILD HAVE A CASEWORKER, SERVICE COORDINATOR OR EI? Check yes____ no_____

NAME OF YOUR PROVIDER/PERSON_____

PHONE_____

15. DOES YOUR CHILD HAVE ONE OF THE FOLLOWING WAIVERS? Check the one that applies to your child.

PDD WAIVER_____ MRRD WAIVER_____ HASCI WAIVER_____

CLTC WAIVER_____ CSW WAIVER_____ OTHER WAIVER_____

16. 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.

_____

_____

_____

17. **DOCTOR'S LETTER: We must have a letter from your child's medical doctor which states the child's diagnosis and confirms that your request is medically necessary and/or medically beneficial for your child. Be sure that this letter is signed by the MD in the practice NOT another practitioner who signs orders.**

Please review the following consents and initial one of the statements for #'s 18 - 21.

18. 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)
19. 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).
20. 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).
21. 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.

I also acknowledge that all information on this application is true and complete. I understand that my child will be ineligible for future grants if my information misrepresents my situation. I am also aware that current funds can be revoked at the discretion of the charity if information is found not to be true. I agree to notify the charity office if I move out of the charity's funding area and will provide updates regarding changes in my child's access to resources that could impact my need for continued funding from the charity.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

Relationship to child: Circle One Parent Grandparent

Foster Parent Other _____

This application cannot be considered until all four pages of this form are completed, signed, and all supporting documents (including doctor's letter) and tax information (the top 2 pages of the previous year's Federal tax return (1040) must be provided if grant request is above $300.00. If you do not file taxes, you must attach a letter that is signed and dated stating that you did not file taxes for the previous year.) is received. If you

choose not to disclose your financial information or provide your tax return, this application will not be reviewed for assistance as this is an audit requirement.

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 _____ $ _____

	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** _____