Children's Life Fund Authority
Wendy Fitzwilliam Paediatric Hospital, EWMSC
Uriah Butler Highway, Champs Fleurs, Trinidad and Tobago
Tel: (868)-225-4673 Ext. 3320-24 Fax: (868)-225-4673 Ext. 3329
Website: www.childrenslifefund.org.tt

Republic of Trinidad and Tobago
Ministry of Health

APPLICATION FORM FOR GRANT UNDER THE CHILDREN'S LIFE FUND AUTHORITY

Patients Personal Information:

Name: _____ _____ _____
(Surname (Block Letters)) (First Name (Block Letters)) (Middle Initial)

Address: _____
_____ **Male** ☐ **Female** ☐

Date of Birth: ____/____/____ **Birth Pin #**: _____ **Nationality**: _____
DD / MM / YY

Relationship to Applicant: _____ **Name of School**: _____

Parents' Personal Information:

Father's Name: _____ **ID/ DP/ PP #:** _____
(Surname, First Name)

Address: _____
Contact Details: (Cell) _____ **(Home)** _____ **(Work)** _____

(Email): _____

Name of Employer: _____

Address of Employer: _____

Mother's Name: _____ **ID/ DP/ PP #:** _____
(Surname, First Name)

Address: _____

Contact Details: (Cell) _____ **(Home)** _____ **(Work)** _____

(Email): _____

Name of Employer: _____

Address of Employer: _____

Applicant's Information:

Name: _____ **ID/ DP/ PP #:** _____
(Surname, First Name)

Address: _____

Contact Details: (Cell) _____ **(Home)** _____ **(Work)** _____

(Email): _____

Parent ☐ **Legal Guardian** ☐ **Medical Social Worker** ☐

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Patient's Medical Information:

Nature of Illness: _____

_____

Referring Specialist: _____

Hospital Address: _____

Additional Information:

1) Is patient covered by any medical insurance? **Yes** ☐ **No** ☐ If yes, please provide:

Name of Insurance Company: _____

Address of Insurance Company: _____

Contact person at Insurance Company: _____

Contacts: (Office)_____ (Cell) _____ (Fax)_____
Email Address:_____

Please state total of insurance coverage: _____

2) Have you done any fundraising or received donations to address the medical expenses? **Yes** ☐ **No** ☐

If yes, please state total received: _____

3) Has the patient ever received government assistance for medical treatment? **Yes** ☐ **No** ☐

If yes, please provide details including amount received: _____

_____

4) Were you ever assessed by a representative from Medical Social Work Department? **Yes** ☐ **No** ☐

If yes, please provide:

Name of Representative: _____ **Date Assessed**: _____
Location: _____

I solemnly and sincerely declare that the information given on this form is correct.

_____ _____ : : Am/Pm
Signature of Parent/ Legal Guardian/ Medical Social Worker **Date (DD/MM/YY)** **Time**

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Monthy Income and Expenditure Statement

INCOME	TTD $	EXPENDITURE	TTD $
Gross Wages/ Salary of family:		***Housing:***	
Husband		Mortgage	
Wife		Rent	
Other Member of Household (List):		***Utilities:***	
1.		Water rate	
2.		Electricity	
3.		Telephone (cell, landline)	
		Cable	
Other Income:		Internet	
Social Benefit			
Child Benefit		***Other:***	
Pension		Loan	
Rental Income		Insurance	
Other		Food	
		Transportation	
		Maintenance	
		Medical Expenses	
		Schooling	
TOTAL		**TOTAL**	

Family Banking Information

**** (You are to list ALL Institutions where accounts are held) ****

1) Name of Account:_____

   Name of Institution & Branch**:**_____

2) Name of Account:_____

   Name of Institution & Branch:_____

3) Name of Account:_____

   Name of Institution & Branch:_____

4) Name of Account:_____

   Name of Institution & Branch:_____

I solemnly and sincerely declare that the information given on this form is correct.

_____ _____ : : Am/Pm

Signature of Parent/ Legal Guardian/ Medical Social Worker **Date (DD/MM/YY)** **Time**

APPLICATION CHECKLIST

The following documents are required to start the Application process:

□ Detailed Medical Report (written within the last 3 months and on an original letterhead) from referring medical specialist which must include:

- Diagnosis of a life-threatening illness
- Treatment is unavailable at a local medical institution
- Signature of referring medical specialist

□ All other pertinent medical reports and test results

□ Completed and signed Application Form for Grant under the Children's Life Fund (CLFA 2011 - 001(revised Jan. 2012)).

□ Completed and signed Authorization to use and/or disclose Information (CLFA 2012 – 010).

□ Copy of Patient's Birth Certificate.

□ Copy of Parents' ID/DP/PP.

□ Copy of Applicant's ID/DP/PP (if different from parent)

□ Copy of Court document if applicant is 'Legal Guardian'.

□ Copy of documents to support family's monthly expenses, e.g. loan statement, rent receipts, utility bills, etc.

□ Copy of bank/saving accounts statements.

□ Statement showing proceeds from fund raising/donations received, or pending receipt.

□ Statement of Insurance Cover from Insurer, if applicable.

□ Letter from overseas health institution accepting patient, detailing proposed treatment plan and estimated cost.

□ Medical Social Worker's report.

Note: Original documents must be presented with copies for verification purposes.