Children's Life Fund Authority
Wendy Fitzwilliam Paediatric Hospital, EWMSC
Uriah Butler Highway, Champs Fleurs, Trinidad and Tobago
Tel: (868)-225-4673 Ext. 3320-25
Website: www.childrenslifefund.org.tt

Republic of Trinidad and Tobago
Ministry of Health

APPLICATION FORM

FOR GRANT FUNDING
UNDER THE CHILDREN'S LIFE FUND AUTHORITY

SECTION A: CHILD'S INFORMATION

Personal Information

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

Address: _____
_____ Male ☐ Female ☐

Date of Birth: / / Birth Certificate Pin #:_____ Nationality:_____
DD /MM / YYYY

Does the Child have a valid Passport? Yes ☐ No ☐ Visa? Yes ☐ No ☐ Country_____

Is the child vaccinated for Yellow Fever? Yes ☐ No ☐

Relationship to Applicant: _____ Name of School:_____

Are there any ongoing legal matters involving the child? Yes ☐ No ☐

If yes, please state:

_____

_____

_____

Medical Information

Nature of Illness: _____

_____

_____

Referring Specialist Name: _____

Referring Specialist Email Address: _____

Referring Specialist Telephone Nos: _____

Medical Institution/Hospital Address: _____

_____

Medical Institution/Hospital Telephone Nos: _____

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Additional Information

1) Was any fundraising done, or donations received to address the medical expenses? Yes ☐ No ☐

If yes, please state total received:_____

2) Has the Child ever received government assistance for medical treatment related to this illness? Yes ☐ No ☐

If yes, please provide details including amount received: _____

3) Is the child covered by any medical insurance? Yes ☐ No ☐

SECTION B: APPLICANT'S INFORMATION

Applicant's Information:

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

Address: _____

Residential Address: _____

Mailing Address: _____

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

Personal Email: _____ Occupation: _____

Does the applicant have a valid Passport? Yes ☐ No ☐ **Visa**? Yes ☐ No ☐ Country: _____

Are there any concerns that may limit your ability to participate in the application, approval, or transfer process?
Yes ☐ No ☐

If yes, please state: _____

Name of Employer: _____

Address of Employer: _____

_____

_____

Employer's Email Address: _____ Telephone No. _____

Parent ☐ Legal Guardian ☐ Medical Social Worker ☐

If approved, is the applicant travelling with the Child? Yes ☐ No ☐

If No, please provide the name of Parent, Legal Guardian, or Medical Social Worker who can travel with the Child:
_____

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SECTION C: PARENT'S INFORMATION

Parent's Personal Information:

FATHER'S NAME: _____ **ID/ DP/ PP #:** _____
(Surname, First Name)

Residential Address: _____

Mailing Address: _____

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

Personal Email: _____ Occupation: _____

Name of Employer: _____

Employer's Email Address: _____ Telephone No: _____

Address of Employer: _____

_____

Name of Next of Kin: _____Telephone No: _____
(Surname, First Name)

What is your relationship status? _____ If married, name of spouse: _____

Medical History:

1) Have you had any current health complications? Yes ☐ No ☐ If yes, please state: _____

2) Are you vaccinated for Yellow Fever Yes ☐ No ☐

3) Are you on medication? Yes ☐ No ☐ If yes, please state: _____

4) Do you have any mental health diagnosis? Yes ☐ No ☐
If yes, please state: _____

5) Any disability? Yes ☐ No ☐ If yes, please state: _____

6) Any language needs? Yes ☐ No ☐ If yes, please state: _____

MOTHER'S NAME: _____ ID/ DP/ PP #:_____
(Surname, First Name)

Residential Address: _____

_____

Mailing Address: _____

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

Personal Email: _____ Occupation: _____

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Parent's Personal Information Cont'd:

Name of Employer: _____

Employer's Email Address: _____ Telephone No: _____

Address of Employer: _____

_____

Name of Next of Kin: _____ Telephone No: _____
(Surname, First Name)

What is your relationship status? _____ If married, name of spouse: _____

Medical History:

1) Have you had any current health complications? Yes ☐ No ☐ If yes, please state: _____

2) Are you on medication? Yes ☐ No ☐ If yes, please state: _____

3) Do you have any mental health diagnosis? Yes ☐ No ☐
If yes, please state: _____

4) Any disability? Yes ☐ No ☐ If yes, please state: _____

5) Any language needs? Yes ☐ No ☐ If yes, please state: _____

Additional Information:

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

Name of Policy Holder: _____

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: _____

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Additional Information Cont'd:

State the type of insurance coverage. Single ☐ Family ☐

Is the child covered under this insurance? Yes ☐ No ☐

Is the Child covered by any additional insurance? Yes ☐ No ☐

If yes, please provide details: _____

If you have medical insurance coverage, indicate Yes ☐ No ☐ for your authorization for the Children's Life Fund Authority's representative to solicit insurance information directly from the relevant insurance broker/agent/official.

Policy Holder's Name (Print) _____

Policy Holder's Signature _____ **Date:** _____

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

_____ _____ : : A.M/P.M
Signature of Parent/ Legal Guardian/ Medical Social Worker **Date (DD/MM/YYYY)** **Time**

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SECTION D: INCOME AND EXPENDITURE INFORMATION

Monthly Income and Expenditure Statement

INCOME				TTD $	EXPENDITURE	TTD $
Gross Wages/ Salary of family:					***Housing:***	
Parents	***Income***					
Father					Mortgage	
Mother					Rent	
Legal Guardian						
Other Member of Household (List):					***Utilities:***	
Other Persons in Household		**Relationship to Parent**	***Age***		Water rate	
1.					Electricity	
2.					Telephone (cell, landline)	
3.					Cable	
4.					Internet	
5.						
Other Income:						
Social Benefit						
Social Welfare $	**Child Maintenance $**	**Disability $**				
					Other Expenses:	
					Loan	
					Maintenance	
					Food	
					Transportation	
Child Benefit					Medical Expenses	
Pension					Education	
Rental Income					Clothing	
Stock & Shares					Entertainment	
Other forms of income					Pension Plan/Annuity	
					Insurance	
					Other:	
					(1)	
					(2)	
					(3)	
					(4)	
TOTAL					**TOTAL**	

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Family Financial Information

You are to list ALL financial institutions where accounts are held.

1) Account Holder: _____

   Type of Account: _____ **BALANCE: $**_____

   Name of Financial Institution & Branch**:** _____

   Address of Financial Institution: _____

2) Account Holder: _____

   Type of Account: _____ **BALANCE: $**_____

   Name of Financial Institution & Branch**:** _____

   Address of Financial Institution: _____

3) Account Holder: _____

   Type of Account: _____ **BALANCE: $**_____

   Name of Financial Institution & Branch**:** _____

   Address of Financial Institution: _____

4) Account Holder: _____

   Type of Account: _____ **BALANCE: $**_____

   Name of Financial Institution & Branch**:** _____

   Address of Financial Institution: _____

I _____**, of** _____
(***Name of Certifier***) (***Address of Certifier***)

certify that I have given a full declaration of the Income, Assets and Liabilities of my/our household and that the particulars contained herein are to the best of my/our knowledge true and correct.

_____ _____ : : **A.M/P.M.**
Signature of Parent/ Legal Guardian/ Medical Social Worker **Date (DD/MM/YYYY)** **Time**

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NOTES:

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SECTION E: INCOME AND EXPENDITURE INFORMATION

AUTHORIZATION
FOR USE & DISCLOSURE OF HEALTH INFORMATION

_____ of _____
Parent/Guardian/Legal Representative — Child's Name

_____ _____
ID/DP/PP No. — Child's (Date of Birth)

_____ _____
Date of Application — Telephone Number(s)

I hereby authorize:

The Children's Life Fund Authority — **Uriah Butler Highway, Champ Fleurs**
Name — Address

To release all health information of _____ to (Recipient)
Child's Name

_____ / _____
Name — Address

- **The authorization applies to the following information:**

  - ***Discharge Summary***
  - ***History & Physical***
  - ***Consultation***
  - ***Operative Report***
  - ***Inpatient Progress Notes***
  - ***Emergency Record***
  - ***Laboratory Test(s)***
  - ***Radiology Report(s)***
  - ***Pathology Report(s)***
  - ***EKG Report(s)***
  - ***Echocardiogram Report(s)***
  - ***Immunization Records***
  - ***Same Day Surgery Record***
  - ***Complete Medical Record***
  - ***Outpatient Clinic Records***
  - ***Radiology Images (X-Rays)***
  - ***Other:***

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I specifically authorize release of the following information:

- ***HIV TEST Results (Initial)*** _____
- ***Substance Abuse (Initial)*** _____
- ***Mental Health (Initial)*** _____
- ***Genetic Testing (Initial)*** _____

_____ _____/_____/**20**____ _____:___**A.M./P.M.**
Signature: Parent/Guardian/Legal Representative ***DD MM YYYY*** ***TIME***