Building 16, Wendy Fitzwilliam Paediatric Hospital
Eric Williams Medical Sciences Complex
Uriah Butler Highway, Champs Fleurs.

(868)-225-4673 Ext. 3321-7
clfa@health.gov.tt
www.childrenslifefund.org.tt

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 Information: Has the referring specialist provided you with information regarding the potential risks of the proposed treatment and the prognosis of the case? Yes ☐ No ☐

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 the illness?

If yes, please provide details including amount received: _____

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

SECTION B: APPLICANT'S INFORMATION

Applicants Information

Name: _____ ID/ DP/ PP#_____

Address_____

Residential Address: _____

Mailing Address: _____

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

Personal Email: _____ Occupation: _____

Does the Application 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 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: PARENTS' INFORMATION

Parents' Personal Information

FATHER'S NAME: _____ ID/DP/PP#_____

Residential Address: _____

Mailing Address_____

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

Personal Email: _____ Occupation: _____

Name of Employer: _____

Employers 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 ☐ If yes, please state:
_____

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**:** _____

MOTHER'S NAME: _____

Residential Address: _____
_____

Mailing Address: _____

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

Personal Email: _____ Occupation: _____

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Parents' Personal Information Cont'd:

Name of Employer: _____

Employer's Email Address:_____Telephone No:_____

Address of Employers:_____

_____

Name of Next of Kin: _____Telephone No:_____

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 ☐

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 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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SECTION E: INCOME AND EXPENDITURE INFORMATION

AUTHORISATION
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 authorisation 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)*** _____

_____ _____ __:__:__A.M/P.M__

Signature of Parent/ legal guardian/ Medical Social Worker **Date (DD/MM/YYYY)** **Time**