



CAREGIVER GRANT APPLICATION

This application must be filled out in its entirety to be considered for a caregiver grant.

1. Date of Application: _____

2. Caregiver Contact Info (Full name, mailing address, phone number, email):

3. Full name, age and relationship of the person you care for:

4. Describe the mental health condition of the person you care for and the details of how you care for them. Include how long you have been caregiving:

5. Explain in detail your need for support (examples: assistance with living expenses, medication, doctors/therapies, respite, transportation, self-care):

6. Explain your lack of financial resources (examples: your income solely supports your loved one, job loss, no insurance, unexpected emergency expenses):

7. Please provide some form of identification such as your driver's license number, state ID number, student ID number, etc. (Attach a copy of the photo ID to this application).

8. How did you learn about AMCF? Be specific and provide name of organization, doctor, support group, social worker, internet search, Facebook, or other social media:

9. Do you know or have any relationships with an employee or board member of AMCF, or have you previously received a grant from AMCF? If yes, be specific and include first and last names:

10. AMCF collects demographic data for grant reporting only:

a. Please provide your race, gender identity, and language spoken at home: _____

b. How many people live in your household: _____

c. Circle your range of income: A) Under \$30,000 B) \$30,000-\$90,000 C) Over \$90,000

11. May we share your caregiving story using first name only in our newsletters and social media accounts? _____

MAIL APPLICATION TO:

OR

EMAIL COPY OF APPLICATION TO:

AGNES MCCARTHY CAREGIVER FOUNDATION
300 CARLSBAD VILLAGE DRIVE
SUITE 108A – 167
CARLSBAD, CA 92008

INFO@AGNESMCF.ORG