Medical Grant Scholarship Fund

THE FAITH FOUNDATION

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Faith Foundation Medical Grant Application

Personal Information

Grant Applicant First Name: _____

Grant Applicant Last Name: _____

Email: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

Apt/Suite#: _____

City: _____

State: _____

Zip: _____

Phone: _____

Are you the applicant? If you are not the applicant, please provide your name and relationship to applicant.

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Medical Information

How many years has the applicant been sick? What is the applicant's current diagnosis?

Describe the applicant's level of disability. Share your Illness Story. Please describe your diagnosis and treatment.

Please describe your current medical need:

Who is your current practitioner (Must be an MD, ND, DO, NP, or PA-C)? Also list additional members of your medical team.

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Financial Information

Do you have medical insurance? If so, what carrier do you have?

What is and is not covered by your insurance for your medical treatment?

Please describe your financial situation and how this poses a hardship to getting treatment.

What is your/your family's combined annual gross income?

How many income earners are in your family?

Do you/your family have other sources of income? (ex: government aid, fundraisers, crowd funding, a grant from an alternative foundation, other family members supporting you)

Describe you/your family's housing situation. For example: Do you own or rent? Do you live with family, and are your living expenses shared?

How did you hear about the Faith Foundation?

Is there anything else you would like to tell us?