THE CHILDREN'S ARK INC.

GRANT APPLICATION FORM

A. APPLICANT PERSONAL DETAILS

1. Name of the Applicant (Must be an immediate family member or legal guardian if the patient is 17 years
   ☐ Mr ☐ Mrs ☐ Ms _____

2. Relationship to Patient
   _____

3. Contact Information
   Mailing Address _____
   E-Mail Address _____
   Mobile Number _____ Home Number _____

B. PATIENT PERSONAL INFORMATION

1. Name of the Patient
   _____

2. Sex ☐ Male ☐ Female 3. Age ☐ Years ☐ Months

4. Current Home Address
   _____

5. Guam Resident ☐ Yes ☐ No

C. TREATMENT DETAILS

1. Name of Hospital or Medical Provider
   _____

2. Medical Diagnosis (Please Attach Medical Supporting Document(s)
   _____

3. Treatment (Please Attach Medical Supporting Document(s)
   _____

4. Patient Has Medical Insurance ☐ Yes ☐ No If yes, answer items 5 and 6.

5. Insurance Provider _____ 6. Plan Name _____

7. Estimated Cost of Medical Treatment

$

8. Family Out-of-Pocket Expenses as of Application Date

$

9. Patient's (household income if patient is a minor) Annual Gross Income

$

10. Please list the names of organizations the patient has applied for financial assistance.

Name of Organization	Date Applied	Amount Approved / Pending / Disapproved / Other

11. Please provide any other information or personal comments that will aid in your grant application.

The information in this Grant Application is true and accurate to the best of my knowledge and belief. I agree to return all Grant money received, upon notice from The Children's Ark Inc, if the above information is determined to be false, with an intention to mislead The Children's Ark Inc. I agree to pay for all attorney fees, court fees, and collection fees if The Children's Ark Inc. must take legal action to enforce the terms of this agreement.

Submitting an application does not guarantee a Medical Grant award.

Applicant's Signature

Date