



We give help, you give hope

GRANT APPLICATION

Incomplete grants will not be considered

For Office Use Only

_____ Date _____ Grant #

Name of Applicant (Please print or type)

Street (Address of Applicant) City State Zip

Gender: Male _____ Female _____
Age _____ Date of Birth _____ Ethnicity (optional) _____

Home Phone Cell Phone E-mail

Does Applicant: Live with family _____ Foster Care _____ ILS _____ SLS _____
Residential Care Facility _____ Other _____

Name of Family Member/Care Home/Service Provider

Address of Family/Care Home/Service Provider City State Zip

Home Phone Cell Phone E-mail

Financial Information: Total Household Income \$ _____ Applicants Income \$ _____
Does family own Home? Yes _____ No _____ Mortgage Payment \$ _____
Rent? Yes _____ No _____ Rental Payment \$ _____

Please check appropriate boxes:
Applicant is a recipient of S.S.I. _____ AFDC _____ Social Security _____ other _____
Is Applicant a Regional Center client? Yes _____ No _____

Case Manager's Name _____ Phone _____

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Degree of mental retardation (mild, moderate or severe) _____

Describe behavioral problem, if any. Is it controlled? _____

Describe physical disabilities, if any _____

Describe what funds are to be used for. (Please attach estimate of cost) _____

Amount Requested \$ _____

Has Applicant applied to other agencies? Yes _____ No _____

If Yes, please list and give \$ amounts committed. _____

Name of Applicant's physician _____

Street _____ City _____ State _____ Zip _____ Phone # _____

I, the undersigned, state that the information contained in this Grant Application is true and correct to the best of my knowledge. I also give permission for the use of name, address and photographs and/or home interview by CARH, Inc.

Signature _____ Title/Relationship _____ Date _____

Revised in January 2011