BESTOWERS FOUNDATION

Spend out of what Lord has provided for you seeking His pleasure alone

6023 NW 107th PL, Alachua, Florida 32615, USA
Web: http://bestowers.org Email: info@bestowers.org
Phone: 571-354-6224 EIN: 46-4846664

APPLICATION FORM – MEDICAL GRANT FOR UNPRIVILEGED

APPLICANT INFORMATION			
First Name:		Last Name:	
SSN / National ID:		Date of Birth	
Address:			
City:		State:	
Zip:		Country:	
Email:		Phone:	
Spouse First Name:		Spouse Last Name:	
Spouse National ID:		Spouse Date of Birth:	

FINANCIAL INFORMATION			
Applicant's Occupation:		Monthly Income:	$
Spouse Occupation:		Monthly Income:	$
Applicant's Assets:			
Spouse Assets:			
Do you own House:	Yes ( ) No ( )	Monthly rent / mortgage:	$
Other Monthly Liability:	$	No of Dependents:	

MEDICAL GRANT INFORMATION	
Requested Grant / Year:	
Purpose of the Grant:	

LIST NAME OF CURRENTLY PRESCRIBED MEDICATIONS, IF ANY, ALONG WITH APROX. PRICES

☐	Upon receiving the medical grant, (i) I do agree to send Yearly medical exam report along with list of current prescribed medication to Bestowers Foundation via email at info@bestowers.org ; and (ii) I authorize Bestowers Foundation to use my name and photo for purposes associated with fundraising and fulfilling foundation's goals.

SIGNATUARE OF THE APPLICAT			
First Name:		Last Name:	
☐	I do hereby certify that above information is correct and true.		
Signature:		Date:	