



BESTOWER FOUNDATION®

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

148 N Lakeside Drive, Kennesaw, GA 30144, USA

Web: <http://bestower.org> Email: info@bestower.org

Phone: 571-469-GIVE Fax: 833-BESTOWR 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			
<input type="checkbox"/>	Upon receiving the medical grant, (i) I do agree to send Yearly medical exam report along with list of current prescribed medication to Bestower Foundation via email at info@bestower.org ; and (ii) I authorize Bestower Foundation to use my name and photo for purposes associated with fundraising and fulfilling foundation's goals.		
SIGNATURE OF THE APPLICANT			
First Name:		Last Name:	
<input type="checkbox"/>	I do hereby certify that above information is correct and true.		
Signature:		Date:	