

For your child to be considered for re-enrollment in the CCCDP Grant Program, this form must be completed in full. This confidential information will be kept private. It is only used to determine eligibility for the program. All questions must be answered to the best of your ability, and the form signed by an adult (parent or guarantor). ALSO your most recent **Federal Tax Forms IRS 1040 and NC State Tax Form D-400**, must be submitted. If they are long, just send in the first two pages of each. If you have not filed tax returns for last year, please contact us.

### Demographics

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
UNC Medical Record Number (MRN): \_\_\_\_\_ SSN: \_\_\_\_\_  
2<sup>nd</sup> Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
UNC Medical Record Number (MRN): \_\_\_\_\_ SSN: \_\_\_\_\_  
Parent #1 Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent #2 Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_  
Email Address(es): \_\_\_\_\_  
Guarantor Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Guarantor Marital Status: \_\_\_\_\_ Does the child live with the Guarator? Yes No

### Employment

Parent #1 Employer: \_\_\_\_\_ How long? \_\_\_\_\_  
Job Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent #2 Employer: \_\_\_\_\_ How long? \_\_\_\_\_  
Job Title: \_\_\_\_\_ Phone: \_\_\_\_\_

### Family

Number of persons in household (dependents), including parents: \_\_\_\_\_  
Name of sibling #1: \_\_\_\_\_ Age: \_\_\_\_\_  
Name of sibling #2: \_\_\_\_\_ Age: \_\_\_\_\_  
Name of sibling #3: \_\_\_\_\_ Age: \_\_\_\_\_  
Name of sibling #4: \_\_\_\_\_ Age: \_\_\_\_\_

### Annual Income

Parent #1 Income: \_\_\_\_\_  
Parent #2 Income: \_\_\_\_\_  
Other annual income (explain): \_\_\_\_\_  
Miscellaneous or one-time income (explain): \_\_\_\_\_  
TOTAL ANNUAL INCOME: \_\_\_\_\_

### Home & Real Estate

Do you own or rent your home?      Own:                      Rent:  
Mortgage balance: \_\_\_\_\_ Lender: \_\_\_\_\_  
Do you own other real estate:      Yes:                      No:  
If yes, describe: \_\_\_\_\_

### Annual Expenses

Rent or mortgage (monthly \_\_\_\_\_ x 12) Total: \_\_\_\_\_  
Utilities (power, water, internet, phones): \_\_\_\_\_  
Vehicle maintenance and fees per year: \_\_\_\_\_  
Medical expenses (in last year): \_\_\_\_\_  
Medical debt payment ( \_\_\_\_\_ x 12) Total: \_\_\_\_\_  
Medical debt balance still owed: \_\_\_\_\_

### Medical Insurance

Medical insurance premiums per year: \_\_\_\_\_  
Medical insurance deductible per year: \_\_\_\_\_  
Name of Company: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Is child covered? Yes                  No                  Policy #: \_\_\_\_\_

### Comments (Any other information that you would like to provide about financial need)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form you certify that the answers provided above are true to the best of your knowledge. You also understand that fraudulent or misleading information will make you ineligible for any financial assistance. We reserve the right to contact your employer or other holders of financial information.

Please direct all questions related to this application to  
[cccdpgrant@unchealth.unc.edu](mailto:cccdpgrant@unchealth.unc.edu)  
Phone: (919) 419-1449