SPECIALIST MEDICAL RESOURCES FOUNDATION APPLICATION FOR FINANCIAL ASSISTANCE

NAME OF APPLICANT

ADDRESS

SUBURB	POST CODE

DATE OF BIRTH	GENDER

PARENT/GUARDIAN NAME (if applicable)

PHONE	MOBILE

EMAIL

NO. OF DEPENDENDENTS IN HOUSEHOLD	AGES OF DEPENDENTS

FAMILY INCOME (net monthly) ***You must attach supporting documentation for verification ie: payslips***

$

FINANCIAL ASSISTANCE (net monthly) ***You must attach supporting documentation for verification ie: Centrelink Income Statement***

$

MONTHLY EXPENSES (approx.)

$

Please tick

Own your home:	Rent:	Board:

PLEASE BRIEFLY OUTLINE YOUR MEDICAL SITUATION

TYPE OF ASSISTANCE REQUIRED

APPROXIMATE TIM E THIS EQUIPMENT WILL LAST (eg 3years)

TOTAL COST INCLUDING GST AND FREIGHT

$

AMOUNT REQUIRED FROM THE SPECIALIST MEDICAL RESOURCES FOUNDATION

$

Are you able to make a financial contribution to the appeal? YES / NO

Have you applied for any Government funding or applied to any other financial sources (other charities etc) for financial assistance? YES / NO

Are you part of a Private Health Fund YES / NO

PLEASE PROVIDE NAME AND CONTACT DETAILS FOR MEDICAL PRACTICIONER RECOMMENDING OR OVERSEEING THE NEED FOR THE PURCHASE

NAME	PHONE	PROFESSION

EMAIL

Please ensure your practitioner fills out the below information.
I,________________________________ of ______________________________ _______hereby confirm that _________________________________ is my patient and I have recommended______________________ ____
to aid in his/her condition. I am willing to be contacted to confirm that all details and need for this grant are true and correct to the best of my ability.

____ ___________________________

Signed Date

Please note that if your medical practitioner cannot be contacted via telephone or in email your application WILL NOT be submitted to the Board for consideration.

If your application is approved would you be interested in joining the Specialist Medical Resources Volunteer Support Group? YES / NO

If your application is successful the Specialist Medical Resources Foundation may wish to publicise its work to both electronic and print media.

I give my consent for the Specialist Medical Resources Foundation to generate publicity should my application be successful YES / NO

PRIVACY COLLECTION STATEMENT

Your privacy is respected by the Specialist Medical Resources Foundation. The personal information you provide on this form (including sensitive information about yours or your loved ones health) will be used to assess your eligibility. It may be provided to organizations that assist us, or as required or authorized by law, but we will not use any of your sensitive information for marketing purposes, without your prior consent. If you have any privacy concerns or would like to verify information held about you, please contact the Specialist Medical Resources Foundation Manager on 0419 213 541.

I consent to the Specialist Medical Resources Foundation collecting the information provided on this form. I understand that if I do not provide the information requested, I may be ineligible to receive assistance from the Specialist Medical Resources Foundation.

Signature

Print Name	Date