SPECIALIST MEDICAL RESOURCES FOUNDATION APPLICATION FOR

FINANCIAL HARDSHIP GRANT

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 i.e.: pay slips***

$

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

$

MONTHLY EXPENSES (approx. including travel, accommodation, treatment, medication etc.)

$

Please tick

Own your home:	Rent:	Board:

PLEASE BRIEFLY OUTLINE YOUR MEDICAL SITUATION

RATE FROM 1-4 WHAT WOULD BEST PROVIDE FINANCIAL RELIEF FOR YOUR CURRENT CIRCUMSTANCES

Woolworths Essentials Card Up to $1000	
Fuel Vouchers Up to $500	
Pharmacy Account Up to $500	
Gas and Electricity Account Payment Up to $500	

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

Are you part of a Private Health Fund? YES / NO

Do you incur out of pocket expenses for your treatment? YES / NO

Is your Specialist/Health Professional located in Wagga Wagga? YES / NO

Do you receive financial assistance for our of town accommodation to undergo treatment? YES / NO

Do you receive funding from the IPTAS program for travel costs? YES / NO

Have you had to leave work indefinitely to undergo treatment? YES / NO

Do you receive a disability pension? YES / NO

Do you receive a carer allowance? YES / NO

Do you have an Income Protection Insurance Policy in Place YES / NO

Do you have a total and permanent disability insurance policy In place YES / NO

PLEASE PROVIDE NAME AND CONTACT DETAILS FOR MEDICAL PRACTICIONER RECOMMENDING AND OVERSEEING TREATMENT

NAME	PHONE	PROFESSION

EMAIL

Please ensure your practitioner fills out the below information.

I,_____ of _____ _____hereby confirm that _____ is my patient and they are/were undergoing treatment for _____.

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