Upper Clutha Children's Medical Trust

APPLICATION FORM A

DATE

HEALTH OR EDUCATION PROFESSIONAL TO COMPLETE
(Referrer cannot be the recipient of funding)

Name, title, phone & email of referrering professional	
Patient's GP and Practice	
Name, residential address, and date of birth of child	
Description of child's problem/formal diagnosis, including any past intervention in relation to the problem	
Name and title of proposed treatment provider, and anticipated treatment, including costs*. Please include name, title and email address of proposed professional.	

*** Retrospective applications will only be considered in extra-ordinary circumstances**

In my opinion, the proposed consultation and treatment is necessary or will be helpful for the child patient.

As far as I am aware, the financial resources of the family are limited, and this cost is likely to result in genuine hardship for the Patient's family

_____ Health or Education referring Professional

Upper Clutha Children's Medical Trust

APPLICATION FORM B **PARENT/GUARDIAN TO COMPLETE**

DATE

Name and residential address of child:	
Name(s) and designation of Child's legal Parent(s)/Guardian(s):	
Name, phone number and email address of contact person:	
Are you presently receiving any funding assistance from Government, Community Organisations, or other sources? Community Services Card Number (if applicable):	
Occupation and employment status of both parents at this time:	
If applicable, do you give permission for us to speak with your child's school?	Yes / No School:
Treatment and Cost	
How much are you able to provide toward these costs? (If parents are not living together are both parents able to contribute?)	
Funding Requested	

Additional Information - (any relevant information assists us greatly in processing your application, attach any reports if appropriate):

IMPORTANT:

I certify that the financial resources of our family are limited, and that this cost of treatment is likely to result in genuine hardship for our family.

_____ Parent/Guardian _____ Date

Please PRINT your name(s): _____

Please return both completed pages of this form, plus any supporting documents, to:
Upper Clutha Children's Medical Trust
P O Box 678, Wanaka 9343
Or scan and email to: info@uccmedtrust.co.nz