APPLICATION FORM FOR FINANCIAL ASSISTANCE

ALL sections of the form must be completed **IN FULL.**
Incomplete forms will not be considered for assistance but referred to the applicant for completion.
All information in the form will be treated as confidential.

This application has been completed by:

Name: ____

Address: ____

Phone: ____________________________________ Date: _______________________________

Email: ____

Relationship to applicant: ____

APPLICANT DETAILS

Name: ____

Address: ____

Email: ____

Phone: ___________________________________ Mobile: _______________________________

Date of Birth: ____

Marital Status: _________________________ Partners Name: ____________________________

Employment status of applicant: ____

Employment status of partner: ____

Is the applicant Aboriginal or Torres Strait Islander origin?	Yes	No
Is the applicant an Australian citizen?	Yes	No
In English the applicants first language?	Yes	No
Does the applicant have private health insurance?	Yes	No
Does the applicant have access to Medicare benefits?	Yes	No
Does the applicant have income protection?	Yes	No

Income (please circle): Centrelink benefit self-funded retiree salary earner other
If other, please explain: ____
Please circle relevant cards held: Health Care card HCC/Pension DVA Gold DVA White

Please circle in relation to lodging: Own home Mortgage Lease Rent State Housing

Do have any investments? (please outline): ____

____

Dependents / Children:

Name/s (first): ____

Age: ____

Has the applicant sought financial support / counselling / consulted with a social worker? (please outline):

____

____

Have you ever been a recipient of MWCBH in the past? Yes No

Please provide details of any funds raised, grants, settlements, go fund me pages, community events, or compensation awarded / pending in relation to this applicant. Please include assistance currently sought from elsewhere (i.e. other charity assistance, benefits etc.):

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Does the applicant have a criminal conviction? (Please outline): ______________________________

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How long has the applicant been a resident in the Midwest region? (Must be a minimum of 12 months)

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MIDWEST
CHARITY
BEGINS
AT HOME

Please explain the diagnosis and details of current treatment:

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Please explain the impact that the illness and treatment has had on current financial circumstances:

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Please explain the impact that the illness and financial situation has had on the applicants social and family circumstances:

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Please give a brief outline of areas and items of need if the application was to be successful and an estimated dollar value that will enable the recipient to obtain these needs"

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REFEREES

To assist Midwest Charity Begins at Home Inc to make a decision as quickly as possible, we require contact details for three referees who can verify the information provided. The first referee **must be your treating medical practitioner.**

Please advise these referees to expect contact from us to discuss your circumstances and needs.

Referee 1: (Medical Practitioner) ____

Phone: ____________________________________ Email: ___________________________________

Referee 2: ___________________________________ Relationship to applicant: _____________________

Phone: ____________________________________ Email: ___________________________________

Referee 3: ___________________________________ Relationship to applicant: _____________________

Phone: ____________________________________ Email: ___________________________________

Please note: Midwest Charity Begins at Home committee reserves the right to make such enquiries as we consider appropriate in the assessment of your application and may contact other than those nominated.

How did you hear about Midwest Charity Begins at Home Inc?: ____________________________________

____

Please check the boxes below to indicate your acceptance of the following terms:

_______ **Further direct contact:**
I accept that a member of the MWCBAH committee will call me to obtain further information or supporting documentation in regard to this application and I agree that I will provide as much information or documentation as requested / necessary.

_______ **Privacy:**
I agree to keep the sum of funds confidential as this helps respect all our recipients both past and present, including in all media interviews.

Promotional Endorsement: (if application successful)

________ I authorise MWCBAH to use any of the information provided in my application for promotional purposes (name withheld unless specific client consent sought).

________ I certify that I have the consent of 'the applicant' in completing this application.

________ I agree to provide a photo opportunity to MWCBAH at the time of the handover of the benefit

________ I am a local resident / member of the Midwest region

________ I understand that the recipient release from and indemnifies the Midwest Charity Begins at Home Inc committee against, all liability that may arise from unforeseen circumstances. The committee's decision will be final and cannot be contested. No correspondence will be entered. The committee reserve the right to limit entry or amend conditions if considered necessary, without notice.

Signature: ____

Date: ____

Declaration of the Applicant

I certify that all of the information given in this application is to the best of my knowledge and belief, correct and that I am the applicant / I am acting on behalf of the applicant.

Signature: ____

Date: ____

If the applicant is under 18 years of age this application must be signed below by the applicant's parent or guardian.

Signature: ____

Date: ____

Relationship to applicant: ____

All applications will be reviewed in a timely manner at the discretion of the committee.
PLEASE NOTE: An original signature(s) is required on this document.
Return to: info@charitybeginsathome.org.au or PO Box 1683, Geraldton WA 6531

PLEASE HAVE YOUR MEDICAL PRACTIONER FILL OUT THE FOLLOWING FORM & RETURN WITH APPLICATION

MEDICAL CONFIRMATION REPORT

Applicant name: ____

Address: ____

Phone: ____

Description of serious illness: ____

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I hereby confirm the condition of this application is considered a serious illness and that the applicant needs financial assistance.

SIGNATURE: ____

NAME: ____

QUALIFICATION: ____

PRACTICE: ____

PHONE: ____

EMAIL: ____

Please confirm that you have signed this form and provided a Doctors signature.

PERSONAL INCOME & EXPENDITURE STATEMENT

MONTHLY INCOME			**PERSONAL**	
Wage 1			Medical	
Wage 2			Hair / Nails	
Pension 1			Clothing / Shoes	
Pension 2			Health Club	
Child Support			Memberships / Fees	
Family Payment			Dry Cleaning	
Austudy / Abstudy			Dentist	
Rent			Chemist / Medications	
Board			Spectacles	
Shares			Toiletries / Cosmetics	
Other Income			Child Support	
TOTAL			Internet	
			TV Subscriptions	
HOUSING / LIVING			Papers / Magazines	
Mortgage / Rent			Alcohol / Cigarettes	
Phone			Personal Spending	
Electricity			Lotto / Gambling	
Gas			Fines	
Water / Sewer			Sports	
Cable			Birthdays	
Waste Removal			Tax Debts	
Maintenance / Repairs			Other	
Supplies				
Land Rates			**INSURANCE**	
Water Rates			Health	
Garden / Lawn Mowing			Home	
Other			Life	
			Ambulance	
OTHER PAYMENTS			Superannuation	
DSS Repayments			Other	
Credit Card 1				
Credit Card 2			**TRANSPORT**	
Store Account 1			Vehicle Payments	
Store Account 2			Bus / Taxi Fares	
Personal Loan 1			Insurance	
Personal Loan 2			Licensing & Registration	
Hire Purchase			Fuel	
Court Order			Maintenance / Repairs	
Other Loans			Other	
			TOTAL MONTHLY	

PERSONAL ASSETS & LIABILITIES STATEMENT

ASSETS	
House	
Car	
Boat	
Motor Bikes	
Caravan	
Farm	
Investment Property	
Other Property	
Shares	
Bank Deposits	
Cash	
TOTAL	
LIABILITIES	
House	
Car	
Boat	
Motor Bikes	
Caravan	
Farm	
Investment Property	
Other Property	
TOTAL	