HELP KIDS LIKE NICK | ABN 13 158 521 263
PO Box 4271 Gumdale Q 4154
P 3890 1843 | **F** 3890 1043 | **E** info@helpkidslikenick.com.au
www.helpkidslikenick.com.au

APPLICATION FOR FINANCIAL ASSISTANCE

Name of Applicant: _____ _____
LAST NAME FIRST NAME

Date of Birth: _____ _____ _____
MONTH DAY YEAR

Address: _____
STREET ADDRESS

_____ _____ _____
CITY / TOWN STATE POSTCODE

Telephone Number: _____ _____
DAYTIME NUMBER MOBILE

Email Address: _____

Bank Details: _____ _____ _____
ACCOUNT NAME BSB ACCOUNT NUMBER

☐ *Medical Confirmation of Wolf-Hirschhorn Diagnosis attached.*

☐ *Proof of Australian Citizenship attached (eg. Birth Certificate or Proof of Residency).*

Parent / Guardian: _____ _____
LAST NAME FIRST NAME

Relationship to Applicant: _____

Equipment and/or Services requested:

How will this benefit the Applicant?

Any additional information you feel will assist the decision-making process (optional):

Total Funding required: **$**

Amount from other sources (please list below):

- Government Agency: **$**
- Non-Government Agency: **$**

Amount required from HELP KIDS LIKE NICK: **$**

Vendor / Service Provider (1):

Vendor / Service Provider (2):

☐ *Please include a copy of the quotes with your Application.*

SUPPORTING HEALTH CARE PROFESSIONAL

Name:

Place of Employment:

Address:

Phone Number:

Email Address:

How long have you known the Applicant?

As a supporting health professional, what benefits do you see this funding will bring the Applicant and their family?

☐ *Please attach independent assessment by the above Health Care Professional.*

CERTIFICATION

I acknowledge that I have read the *Help Kids Like Nick Guidelines for Funding* and certify that the information provided in this Application is true, correct and complete to the best of my ability.

Parent / Guardian:

SIGNATURE

PRINT NAME

DATE