

APPLICATION FORM HEALTH AND WELLNESS GRANT		
MR/MISS/MS/MRS/OTHER FIRST NAME:		SURNAME:
DATE OF BIRTH:  AGE:		Male / Female / Other / Prefer not to say
ADDRESS:		
TOWN/CITY:		POSTCODE:
PHONE:	MOBILE:	EMAIL:
IF YOU ARE CURRENTLY IN PRISON, WHAT IS YOUR EXPECTED RELEASE DATE?		
ARE YOU REGISTERED WITH THE FORDE FOUNDATION?		YES / NO
If you are not registered with the Forde Foundation, please complete and return a Forde Foundation Registration Form.		
WHAT TREATMENT / ITEMS DO YOU REQUIRE AND <b>WHY?</b> (you may attach a separate page)		
IS THIS TREATMENT / ITEM PARTIALLY COVERED BY <b>MEDICARE</b> , YOUR <b>PRIVATE HEALTH INSURANCE</b> OR <b>OTHER STATE/FEDERAL PROGRAM</b> (e.g, <b>Federal Government's My Aged Care</b> , <b>NDIS</b> ) OR <b>CONCESSION?</b> <b>IF SO, WHICH PROGRAM/S AND FOR WHAT AMOUNTS?</b>		
WHAT IS THE URGENCY FOR THIS TREATMENT/ ITEM:		LOW / MEDIUM / HIGH

HOW WILL THIS TREATMENT/ ITEM HELP YOU? (please tick one or more)

The definition of *advancing* includes protecting, maintaining, supporting, researching and improving.

- ☐ Advancing health - preventing and relieving sickness, disease or human suffering
- ☐ Advancing social or public welfare
  - relieving the poverty, distress or disadvantage of individuals or families
  - caring for and supporting the aged; or individuals with disabilities.
- ☐ Other benefit that may be regarded as comparative to, or within the spirit of, any of the purposes mentioned above – relieving the necessitous/need\* circumstances of one or more individuals who are in Australia.

\* 'needy' was inserted by the Board for clarity

NAME OF PROVIDER:

PROVIDER'S ADDRESS:

TOTAL AMOUNT QUOTED: \$

ITEMISED QUOTE ATTACHED ☐ Yes

To assist with my grant application I have attached:

- ☐ brochures or details about the item or service
- ☐ documents to show that the item or service is likely to assist me
- ☐ documents to show how similar items and services have assisted me in the past
- ☐ documents to prove that the item or service is not fully covered by Medicare, my private health insurance or a state or federally funded program

#### Privacy Notice

The Forde Foundation will collect your personal information to assess your grant application. If the Forde Foundation makes recommendations to the Public Trustee to approve your grant, your personal information will be disclosed to the Public Trustee for his approval and payment of the grant from the Forde Foundation Trust Fund. Your personal information may also be disclosed to your health provider to arrange payments and a treatment plan.

#### Declaration

I have read the guidelines and fully understand that my application may not be successful and decisions of the Forde Foundation are final.

I declare that the information in this application is correct to the best of my knowledge.

I hereby give my consent for the Forde Foundation to contact my provider to discuss payments and a treatment plan.

I hereby give my consent for the Forde Foundation to provide my grant details to the Public Trustee if my grant application is successful in order that the Public Trustee may make payment(s) from the Forde Foundation Trust.

Signature:

Date:

**Please return completed form to:**  
The Forde Foundation, Locked Bag 3405, Brisbane, Qld, 4001  
**or email to:**  
fordefoundation@dcssds.qld.gov.au