

## **APPLICATION FOR FINANCIAL ASSISTANCE FROM OXFORD HBOT KIDS FOUNDATION**

The Oxford HBOT Kids Foundation will consider requests for help with alternative therapies or medical treatments not covered by insurance. Most financial help will only be for a portion of the treatment, therefore it is advised that you continue fund-raising efforts along with this grant application. The grant money will only go directly to the therapy/medical center, not to an individual. If the allotted grant money is not used up for the therapy it will be returned to the Foundation.

### **HOW TO APPLY:**

Please complete this application form and attach a letter of support from your occupational therapist or social worker and, where possible, two quotes for the cost of the item required. **Please note that we do not fund items retroactively.**

Please keep a copy of the application form and supporting documents for your reference. It is important to provide as much information as possible about your request so that your application can be processed without delay. Your application will be treated in confidence and will usually be considered within four weeks.

### **ALTERNATIVE FUNDING**

Where appropriate, we require that alternative funding be explored prior to applying for this grant. For example you may find that you are entitled to a grant from your local Rotary Club, or other charitable organization.

### **SAVING LIMITS**

Please note that the Oxford HBOT Kid's Foundation is unable to consider requests for financial assistance from applicants with over \$16,000 in savings,

after any personal contribution toward the cost of the request has been taken into consideration. Additionally, we would expect applicants with over \$8,000 in savings to make a contribution toward the cost of the request.

**Please read the notes on page 1 before starting to complete this form.**

**PART 1. ABOUT THE APPLICANT**

Please complete as fully as possible.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone (home): \_\_\_\_\_ (cell): \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Name of child: \_\_\_\_\_

Child's date of birth \_\_\_\_\_

**Please give the name and address of your doctor.**

We will not contact your doctor if you do not consent. However, by signing this form you are giving permission for the foundation to contact any primary care physician or specialist listed here.

Name: \_\_\_\_\_

Address \_\_\_\_\_

Name: \_\_\_\_\_

Address \_\_\_\_\_

Name: \_\_\_\_\_

Address \_\_\_\_\_

Do you have a spouse/partner? · No · Yes

Is there another adult in the household? · No · Yes

If yes, what is their name: \_\_\_\_\_

What is his/her occupation? \_\_\_\_\_

Is your home: • Owner occupied • Privately rented • Staying with friend/family

How many other children are living in the home? \_\_\_\_\_

Are there any other children living in the home who have a disability? • No  
• Yes

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

## **PART 2. YOUR INCOME**

Do you or your child get one of the following benefits, please check the relevant box and sign to confirm: • Child and/or Support • Income-related Employment

• Unemployment • Disability income • Other: \_\_\_\_\_

### **Your present or most recent occupation and employer:**

Employer name and address.

Occupation: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Employer: \_\_\_\_\_

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### **Your spouse/partner's present or most recent occupation and employer:**

Employer name and address.

Occupation: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Employer: \_\_\_\_\_

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**Please list any other occupations you and/or your spouse/partner have had in the past.**

Please give dates if possible.

You: \_\_\_\_\_

\_\_\_\_\_

Spouse/partner: \_\_\_\_\_

\_\_\_\_\_

**If you, or a member of your family has been in the armed forces, please give details.**

Name: \_\_\_\_\_ Service: \_\_\_\_\_

Rank and number: \_\_\_\_\_ Period of service: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Type of discharge:

Please give details of your **household** income and expenditures, as this will help us to ensure you are receiving all the benefits and other income to which you may be entitled. Disability Living Allowance and Attendance Allowance will not be considered as income. Please use **monthly** figures.

**INCOME (PER MONTH)**

**EXPENDITURES (PER MONTH)**

Earnings of applicant		Mortgage/rent	
Earnings of spouse/partner		Electric	
Child support		Cell Phone	
Spousal support		Cable/Satellite/TV	
Disability		Car Loans	
Pension		Gas	
Stocks/bonds		Student loans	
Investment properties		Health Insurance:	
Other (define)		House/car insurance	
Other (define)		Credit card payments	
		Home Equity Loans	
		Child care	
		Food	
		Dining out	
		Other (define)	
		Other (define)	
<b>TOTAL MONTHLY INCOME</b>		<b>TOTAL MONTHLY EXPENSES</b>	

**PART 3 SAVINGS.**

All applicants must complete this section.

Do you have any savings, capital or investments? · Yes · No

If yes, please give details. If you are making a contribution from your savings, please indicate the amount remaining. We will not consider grants for applicants with over \$16,000 in savings.

TYPE OF SAVINGS/INVESTMENTS	AMOUNT

Please use this space to mention anything else about your income, expenditures or savings which might be of interest in considering your request. For example, a high level of savings may require that you make a contribution toward the cost of your request if you have not already done so. If there is any additional information that we should know about your savings, please include it here.

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Please use this space to tell about other sources of funding that you have explored or for which you have applied:

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**I hereby the Oxford HBOT Kid's Foundation permission to use this information to seek funds from other organizations in relation to this application. I declare that the above information is true to the best of my knowledge.**

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_