“A local charity dedicated to ease the extra financial burden placed on patients and their families while undergoing treatment for cancer, living in Canberra and Queanbeyan”

APPLICATION FOR FINANCIAL ASSISTANCE

Instructions for the applicant

1. **Please complete all requested details, including spouse, children and authorized representative**
2. **Please sign form**
3. **When form has been completed, return it by post, email or in person to:**

21 Cooma Street
QUEANBEYAN NSW 2620
admin@ULMDERYHFEUg.au

*Privacy and your personal information

This form must be completed for all financial assistance. Completing this form acknowledges that your personal details may be available on a strictly confidential basis, with other health professionals and/or treatment organizations in order for financial assistance to be authorized and approved

IMPORTANT INFORMATION FOR THE APPLICANT

Eligible Items:

- One off payment for electric/gas bill
- Food/Fuel vouchers – limit of $100 per week
- Pharmacy account – to be used for the sole use of medications related to current cancer diagnosis
- Supplement Drinks – delivery of drinks once per month
- Chemotherapy Treatment
- Bulk Billed Scans
- Half price MRI

Exclusions:

- Transport and transport costs
- Rent/mortgage payments
- Car Registration
- Medical equipment
- Breast prostheses
- Diagnostic Tests
- Bills for non-essential services
- Funerals

What happens next?

- This application will be assessed
- Approval will be communicated directly to the patient
- Types of assistance available will be discussed with patient

If you have any questions about this form, please call us on (02) 62971261 or email admin@MDERYHFEUorg.au

Information for the Health Professional

Completing this form

In this form, you will be asked to provide information about your patient’s medical condition(s). Please complete all the required questions in this form.

- **Please complete all fields**
- **Include your details and organistaion**
- **Please include treatment plan information available to you**
- **Please sign as referrer**

Returning this form

You can give this form to your patient or return it directly to:

M$ERYH
21 Cooma Street
QUEANBEYAN NSW 2620
admin@ULMDERYHFEUg.au

Thank you for your assistance.

Patient's details

Family name | Given name(s)

Address

Postcode | Phone

Email

Aboriginal or Torres Strait Islander Y ☐ N ☐

Date of birth / /   Concession/Pension Card Holder Y ☐ N ☐

Monthly Household Income: $ **Monthly Household Expenses: $**

Diagnosis — Please list the main medical conditions which **significantly impact** on the patient's capacity to work

Date of diagnosis

Assessment — **1 –** Temporary, **2 –** Permanent (likely to persist for 2 years or more), **3 –** Prognosis unclear

Tick ONE only 1 ☐ 2 ☐ 3 ☐

Prior Medical Conditions — Please list any prior conditions

Treatment — Please describe the patient's current treatment plan

Current

Treatment Plan:

☐ 6 months ☐ 12 months ☐ Palliative

Patient's spouse or authorized representative (name and contact details required)

Details of children living at home (name, date of birth)

Details of referrer completing this form

Name:

Title:

Hospital or Organisation:

Address:

Telephone:

Email:

Signature   **Date**