

Application ID: \_\_\_\_\_\_\_\_\_\_\_

JMBF Office Use Only

**James Macready-Bryan Foundation**

**Funding Application Form**

**NOTE:** Only applications submitted on this form will be considered

1. APPLICANT’S PERSONAL DETAILS

|  |  |
| --- | --- |
| **Name:** |  |
| **Address:** |  |
| **Date of birth:** |  |
| **Age:** |  |
| **Guardian/carer’s name:** |  |
| **Relationship to applicant:** |  |
| **Is the guardian aware of this application?** | **YES  NO** |
| **Address for correspondence:** |  |
| **Contact phone number:** | **Home/office:** |
| **Mobile:** |
| **Email address for correspondence:** |  |
| **Date of application:** |  |
| **How did you hear about JMB Foundation funding?** |  |

1. AUTHORISED FUND ADMINISTRATOR

|  |  |
| --- | --- |
| **Administrator’s name\*** |  |
| **Organisation** *(if applicable)* |  |
| **Relationship to applicant:** |  |
| **Address for correspondence (postal address)** |  |
| **Email address** |  |
| **Contact phone number:** | **Office:** |
|  | **Mobile:** |
| \*The authorised fund administrator is the applicant’s legal guardian or authorised agent (e.g. case manager) who undertakes responsibility for submitting this application and, if successful, ensuring appropriate documents/invoices are presented to JMBF for payment | |

1. APPLICANT’S BACKGROUND

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of ABI:** |  | | |
| **Date ABI occurred:** |  | | |
| **Cause of ABI:** |  | | |
| **Functional capacity:** | *Please indicate (X) whether the applicant is independent, uses aids and/or requires assistance* | | |
| * **Mobility:** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |
| * **Communication:** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |
| * **Personal care:** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |
| * **Domestic activities** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |
| * **Community activities** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |
| * **Transport** | **Independent** | **Uses aids** | **Requires assistance** |
|  |  |  |  |
| **Current residence:**  *Please provide applicant’s residential address.* |  | | |
| **Type of accommodation:** | **Private/family home  Supported accommodation** | | |
| **Current level of care:**  *e.g. full time, 20 hrs per week, care provided on a 24 hour basis by accommodation, etc* |  | | |

|  |  |
| --- | --- |
| **Is the applicant on Department of Human Services Disability Support Register (Victoria) or equivalent register in applicable Australian State of residence?** | **YES  NO**  **State:**  **Register:** |
| **Is the applicant pursuing compensation through the courts?\*** | **YES  NO** |
| \*If YES there is an expectation that any funds provided by JMBF will be reimbursed to JMBF, if the applicant is successful in securing compensation. Please refer to Application for Funding Guidelines document for further information. | |

1. CURRENTLY FUNDED SERVICES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Currently  funded services** | **Funded by** | **Level of funding**  *eg 2 hours per week* | **Basis -**  **On-going** | **One-off** | **Until (end date)** |
| **Attendant care:** |  |  |  |  |  |
| **Therapy:** |  | | | | |
| * Occupational therapy |  |  |  |  |  |
| * Physiotherapy |  |  |  |  |  |
| * Speech therapy |  |  |  |  |  |
| * Neuro-psychology |  |  |  |  |  |
| * **Other Please state type of service and funding source (eg music therapy)** | | | | | |
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1. OTHER APPLICATIONS FOR FUNDING

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Has the applicant previously applied to JMBF for funding?** | **YES  NO** | | | | |
| **If yes, please provide details of previous application/s**  **\*Funding period applied for – January-June or July-December, year.**  **#Total amount paid by JMBF. (This may be less than total amount applied for).** | **Funding period\*** | **Amount of**  **application** | **Amount granted** | **Purpose**  **of funds** | **Amount**  **Accessed#** |
|  | $ | $ |  | $ |
|  | $ | $ |  | $ |
|  | $ | $ |  | $ |
|  | $ | $ |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Pending funding applications to bodies other than JMBF** | | Please provide details of **all** other applications for funding currently under consideration for this applicant | | |
| **Funding body** | **Amount requested** | | **Purpose** | **Time period to which funding would apply (if granted)** |
|  | $ | |  |  |

1. DETAILS OF APPLICATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Purpose of funds requested**  Please list service required (eg therapy/attendant care etc, and/or describe equipment (include make and model) | | | **Provider\***  eg: agency, health professional that will provide service/supplier of item of equipment | | **Cost basis**  Please state whether funds are to cover a one-off cost, or provide details of frequency and duration, of service/s over 26 week funding period, and hourly rate to be charged\*\* | | | | | | **GST** | **Total amount  (inc GST)** |
|  | | |  | | One-off cost | | OR | | Hours per week | Hourly rate | GST | $ |
|  | $ | $ |
|  | | |  | | One-off cost | | OR | | Hours per week | Hourly rate | GST | $ |
|  | $ | $ |
|  | | |  | | One-off cost | | OR | | Hours per week | Hourly rate | GST | $ |
|  | $ | $ |
|  | | |  | | One-off cost | | OR | | Hours per week | Hourly rate | GST | $ |
|  | $ | $ |
|  | | |  | | One-off cost | | OR | | Hours per week | Hourly rate | GST | $ |
|  | $ | $ |
| **Total amount of application (inc GST)** | | | | | | | | | | |  | **$** |
| **\*** Please attach provider’s quotation/written estimate where possible.  \*\* In the case of hourly rates, please note the amount requested should reflect the rate that will be charged by therapist/carer during the six month period to which this application applies. In the event of an increase in hourly rates subsequent to any notification of approved funding, the JMB Foundation will NOT meet additional costs. | | | | | | | | | | | | |
| **PART-CONTRIBUTIONS In the event that JMBF cannot fund this application in full, please indicate whether a part-contribution to costs as detailed above would be acceptable.** | | | | | | **YES** Partial funding will assist.  **NO** If this application cannot be funded in full the proposed activity/purchase cannot proceed. | | | | | | |
|  | |  | | | | | | | | | | |
| **STATEWIDE EQUIPMENT PROGRAM (SWEP)**  **If you are applying for gap funding to enable the purchase of aids and/or equipment via SWEP, please indicate the status of your SWEP application.** | | | | | | | | | | | | |
| **Date of SWEP application** | **Total amount SWEP will pay** | | **Category** | **Do you expect SWEP funding to become available during the  26 week funding period to which this application applies?** | | | | | | | | |
|  | **$** | |  | **YES** | **NO** | | | **If no, what is the estimated date that funding will become available? \_\_\_\_\_\_(month) 20\_\_\_\_(year)** | | | | |

1. BENEFIT TO THE APPLICANT

**Please describe how and why this item or service will benefit the recipient.  
NB: Written support from recommending authority (doctor, therapist etc) may be submitted with this application, or may be requested by   
JMB Foundation upon consideration of this application.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Aim** (*Overall aim, applicant’s goal/s)* | **Objective** *(Steps to achieve aim/ goals)* | **Strategy** *Hhow objectives will be achieved, activities, timeframe)* | **Outcome** *(What will change, how results will be measured)* |
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1. FUND ADMINISTRATOR DECLARATION

I have read the application guidelines and agree to comply with the requirements therein.

Should this application be successful, I agree to fulfil my responsibilities as the fund administrator, in administering the funding on behalf of the applicant.

I declare that the information provided in this application is true and correct and in accordance with the application guidelines and I agree, if any information herein is found to be incorrect or misleading, that the James Macready-Bryan Foundation reserves the right to seek repayment of all or part of any moneys provided.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Fund Administrator)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Witness)

Email this completed application form to:

[applications@jmbfoundation.org.au](mailto:applications@jmbfoundation.org.au)

Or send to:

**JMBF Applications for Funding Subcommittee**

PO Box 2281

Hawthorn Vic 3122