

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**

|  |  |
| --- | --- |
| **Applicant’s name:** |  |
| **Applicant’s 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:** |  |
| **Email address for correspondence:** |  |
| **Date of application:** |  |
| **Where did you hear about JMBF funding?** |  |

1. **APPLICANT’S BACKGROUND / CURRENTLY FUNDED SERVICES**

|  |  |
| --- | --- |
| **Date of ABI:** |  |
| **Cause of ABI:** |  |
| **Functional capacity:** | *Please indicate (tick) 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 address and state whether home or supported accommodation*  |  |
| **Current level of care:***e.g. full time, 20 hrs per week, care provided on a 24 hour basis through accommodation, etc* |  |
| **Currently funded services** | **Funder** | **Level of funding***e.g. 2 hours per week* | **Ongoing or one off** |
| * **Attendant care:**
 |  |  |  |
| * **Therapy:**
 |  |  |  |
| * OT:
 |  |  |  |
| * PT:
 |  |  |  |
| * SP:
 |  |  |  |
| * Neuropsychology
 |  |  |  |
| * **Other – please state type of service and funding source.** e.g. music therapy
 |  |  |  |
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1. **AUTHORISED FUND ADMINISTRATOR**

|  |  |
| --- | --- |
| **Administrator’s name\*** |  |
| **Organisation** *(if applicable)* |  |
| **Relationship to applicant:** |  |
| **Address for correspondence:** |  |
| **Contact phone number:** |  |
| **Email address for correspondence:** |  |
| \*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. **OTHER APPLICATIONS FOR FUNDING**

|  |  |  |
| --- | --- | --- |
| **Has the applicant previously applied to the JMB Foundation for funding?** | **YES** | **NO** |
|  |  |
| **If yes, please provide date/s of previous application/s** | **Date/s** |
|  |
| **Was the application successful?** | **YES** | **NO** |
|  |  |
| **If successful, please provide date and total amount received.** | **Year** | **Amount received** |
|  | **$** |
| **What did the JMBF funds go towards?** |  |
| **Is the applicant on Department of Human Services Disability Support Register?** | **YES** | **NO** |
|  |  |
| **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. |

|  |  |
| --- | --- |
| **Pending funding applications** | *Please provide details of* ***all*** *other applications for funding currently under consideration for this applicant* |
| **Funding body** | **Amount requested** | **Purpose** | **Time period of funding** |
|  |  |  |  |

1. **DETAILS OF APPLICATION**

|  |  |  |
| --- | --- | --- |
| **What for?***Please list/describe equipment (include make and model) or service and provider.*  | **Time frame***Please state frequency of service or one off cost & beginning and end of service* | **Total amount requested\*** |
|  |  |  |
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|  |  |  |
| **Total amount applied for** | **$..........** |
| **\*In the case of hourly rates, please note the amount requested should reflect the rate that will be charged by the relevant therapist/carer during the six month period to which this application applies.**  |

1. **BENEFIT TO THE APPLICANT**

**Please demonstrate how and why this item or service will benefit the recipient.
NB: Written support from recommending authority (doctor, therapist etc) may be requested.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Aim**(*overall aim, applicants goal/s)* | **Objective***(steps to achieve aim/ goals)* | **Strategy***(how 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 monies provided.

Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) - Fund Administrator

Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) - Witness

Email this completed application form to:

applications@jmbfoundation.org.au

Or send to:

**JMBF Application for Funding Sub Committee**

P.O. Box 2281,

Hawthorn Vic 3182