SHROPSHIRE Cerebral Palsy SOCIETY

Date Application Received: ..... /..... /.....

Trustee Meeting Considered: ..... /..... /.....

Therapy Grant Application Form

APPLICATION NOTES

The form can be filled out using Adobe Acrobat. This is free software that can be downloaded from the link below if it is not already pre-installed on your device.

https://get.adobe.com/uk/reader/

Alternatively this form can be printed and manually filled in - this can then be posted or emailed back to us.

- We are unable to consider your application without all relevant or supporting documentation.
- If any information is missing from your application this will delay your request.
- If we need to contact you to request outstanding information but do not hear from you within 2 months from the date we contact you, we will close your request.
- No monies will be paid to individuals, **only suppliers of goods or services**, by cheque or debit card only.
- No monies will be paid retrospectively to any requests under any circumstances.
- Any personal information you give to us will be processed in accordance with the General Data Protection Regulation 2018

All fields must be completed to enable your application to be considered. We will consider applications for therapy grants to the value of £400 or 10 sessions a year, with a maximum of two applications per year.

1. APPLICANTS DETAILS

Does the person have cerebral palsy?			
Is this a first time application?			
If Yes - please enclose proof of diagnosis. E.G. Letter from a health professional.			
Full Name:		Date of Birth:	
Telephone Number:			
Address:			
Postcode:		Email Address:	

2. NAME OF PERSON COMPLETING THIS FORM (if different to above)

Full Name:		Telephone No:	
Relationship to Applicant:			
Address:			
Postcode:		Email Address:	
How did you find out about us?			

3. THERAPY GRANT APPLICATION

You must complete all questions in this section and send us all requested documentation along with this application form.	Tick to show you have completed/enclosed required paperwork
3.1 Please tell us why you would like to apply for a grant towards paying for therapy and how this will directly benefit the applicant. (Continue on a separate piece of paper if necessary)	☐
3.2 Please provide a detailed supporting leter from a health professional. This needs to clearly detail how the requrested therapy will benefit the applicant. Please advise us if this is not possible.	☐
3.3 Please provide a detailed invoice from the therapeutic service.	☐

4. OTHER CHARITIES AND ORGANISATIONS

Have other charities or organisations been approached? What has been the response? Please note that we may contact them directly if required.

1.	
2.	
3.	

5. CONSENT AND SIGNATURE

By submitting your application you are consenting to your details being kept on our SCPS database.
We would like to contact you regarding out future events. *Please tick here if you wish to be kept informed*: ☐
If you are interested in volunteering and would like us to contact you to discuss this please tick here: ☐
Digital signatures will be accepted.

I confirm that the information on this form is correct.

Name		**Date**	
Signature			

WHERE TO SEND YOUR APPLICATION AND SUPPORTING DOCUMENTS

BY POST: Shropshire Cerebral Palsy Society, PO BOX 265, Oswestry, Shropshire, SY10 1FB

BY EMAIL: enquiries@shropshirecerebralpalsysociety.co.uk