FOR OFFICE USE ONLY

Special Individual Needs Application Form

Applicant's Name BLOCK CAPITALS THROUGHOUT PLEASE	Mr/Mrs/Miss/Ms
Address	 Post Code
Telephone Number	☎
	E Mail:
Date of Birth	

Please tell us about your disability and how this affects you?

For what purpose do you require a Grant - how will the provision improve your health care?

Who is supporting your application?	Name
Telephone Number	☎	E mail

What is his/her profession?

☐ Doctor ☐ Nurse ☐ Occupational Therapist ☐ Physiotherapist ☐ Social Worker ☐ Other

Has an assessment of your need ever been made by Social or Health Services? ☐ YES ☐ NO

If YES, when was the assessment carried out and what was the result?

If NO, why not?

Please describe the equipment required. Enclose a written quotation.
If you are applying for funding for a scooter, we will need a completed assessment form to demonstrate safe use, storage and maintenance before we can consider the application.

Cheques cannot be paid to individuals.
Please indicate a local charity or a supplier who could process any donation for you.

If you do not belong to any such group, please put a tick here ☐

Finances of Person needing help

Replies to this section are mandatory and are essential to us in considering this application. Although any grant is not means tested, the purpose of this fund is to assist people with limited means to meet the special individual health needs above and beyond statutory provision.
If the person applying is under 18, the entire family income should be recorded.

Please list any Salary / Income / Benefits / Allowances below:

Income / Salary	£
DLA Care / PIP Daily Living	£
DLA Mobility / PIP Mobility	£
(How is this being used?)	
Income Support	£
Child Benefit	£
Pension	£
Savings	£
Other Benefits e.g. Universal Credits, Tax Credits	£
Total Annual Income	**£**

What is the total cost of the equipment?	£
Amount requested from Catalyst?	£
What contribution could you make?	£

Please note, we never fully fund any equipment, a reasonable contribution will be expected.

Funding from other sources?

If you are completing this form for the Applicant, please give your name, address, relationship telephone number and E Mail address.

Representative's Name	Mr/Mrs/Miss/Ms	
Address	✉	
	Post Code	
Relationship to Applicant		
Telephone Number	☎	E mail

DECLARATION *(to be completed by Applicant or Representative)*

I declare that the information given in this form is correct and complete and I am aware that this application will be discussed with relevant health professionals and/or other charities in order to help Colchester Catalyst Charity make a decision on my application.

Signature of Applicant / Representative* Date

*please delete as appropriate

If signed by a Representative, explanation why Applicant is unable to sign

Please return form to:

✉ **Colchester Catalyst Charity,**
3 Dedham Vale Business Centre,
Manningtree Road, Dedham,
Colchester, Essex CO7 6BL

☎ **Tel: 01206 323420 Fax: 01206 323836**

E Mail: info@colchestercatalyst.co.uk
www.colchestercatalyst.co.uk