Irish Motor Neurone Disease Association

Charlie Bird Development Fund (CBDF)

Travel Grant Application

Background
We are so thankful to Charlie and Claire who dedicated all their time and energy to making their "Climb with Charlie" so successful. It is their wish that monies raised for IMNDA go towards a project that makes a difference to the lives of those who live with this disease.

The IMNDA's Mission is to support people living with Motor Neurone Disease (MND), their families and carers through advocacy, home and professional support. Following on from a survey with clients, family and carers, on their needs, we have established a Travel grant to assist with some of the expenses of traveling to medical appointments. This is a once off grant, maximum of €200.

Before processing this application, please ensure:

- The client is in genuine financial need.
- All sections of this application are completed.
- Consent of client/NOK is obtained.
- HCP has signed the application with relevant contact details.
- The form is legible.

Eligibility Criteria

- Client is living in Ireland.
- There is a confirmed diagnosis of MND.
- The individual is registered with IMNDA.
- The grant is used to travel to and from medical/healthcare appointments.
- The client is having difficulty with the cost of attending these appointments.
- Appointments must be made within month from when you apply or be taking place in the near future.

How to Apply
Applications for CBDF Travel Grant are made on behalf of the person living with MND by a healthcare professional, such as a medical social worker, IMNDA Nurse or another healthcare professional involved in the persons care.

The person is also required to sign this form. If they are medically unfit to do so, then a next of kin may sign.

Complete and post the application form to:

IMNDA,
Unit 6 Bond House,
9-10 Bridge Street Lower,
Dublin 8
D08TH76.

If you have any questions about this form, please call IMNDA Services Team on (01) 670 5942.

Applicant Information

Date of Application:
Date Application posted:

Date of MND Diagnosis: Diagnosing Hospital:

Amount being applied for: € max

Full Name of Healthcare Professional making application:

Signature: _____

Distance to medical appointment in km

Patient Information

To be completed in **BLOCK CAPITALS** by a medical social worker, IMNDA Nurse or other healthcare professional involved in the persons care.

Full Name: _____
First *Last*

Address: _____
Street Address

_____
Town/City *County* *Eircode*

Phone: _____ Email _____

Date of Birth
DD/MM/YYYY: _____

Medical Card Holder: YES ☐ NO ☐ Application pending: YES ☐ NO ☐

If no, please outline reasons?

Briefly outline employment status: unemployed

Has patient availed of other transport services:

Has patient received a CBDF Travel Grant previously:

Hospital or Treatment Centre: Type of Treatment

Number of appointments to attend:

Public transport cost: Private transport cost:

Bank Details

Please provide bank account or credit union details for payment. Please outline the full name as it appears on the account. Where a patient has no account, please give next-of-kin (NOK)'s account details. A cheque can be provided in exceptional circumstances.

Name: _____ NOK: _____

Bank: _____ Branch: _____

Name on Account: _____ IBAN:

Swift code/ BIC number: _____

Please ensure that the above details are correct as the IMNDA cannot accept liability for payments to incorrect accounts.

Consent

Consent of patient or next-of-kin:

I understand and agree that, and expressly consent to, the personal and medical information requested by IMNDA and provided about me on this form will be used for the CBDF Travel Grant administration and auditing purposes only. This information will not be passed to any third parties without prior written consent.

I believe the facts in this form to be true.

First Name: _____ Surname: _____

Signature: _____

Applicant -
NOK: _____

Healthcare Professional Details

Full name: _____

Job Title: _____

Date
DDMMYYYY: _____

Email: _____ Phone: _____

Address: _____

Date of
application
DDMMYYYY: _____

I am satisfied that this patient is in genuine financial need, and I believe that the facts stated on this form are true and accurate:

Signature: _____

IMNDA USE ONLY

AIG GL 208 CDDF Travel Grant

Date Received: _____ Approved Yes: _____ No: _____

Reason, explain: _____

Signature: _____

Payment amount:

Patient First name: Surname:

Date:
Application Service Requisition Number: