



## Support Grant Program: Application Form

### Applicant details:

Name:

DOB:

Address (postal):

Email:

Phone Number:

**If applying as direct caregiver for a person with FOP, please include their details:**

Name:

DOB:

Address (postal):

Email:

Phone Number:

**Treating doctor (who can confirm the diagnosis of FOP if required):**

Name:

Practice:

Address (postal):

Email:

Phone Number:

### Eligibility criteria and consent for release of information

Tick each box to declare that you meet the following criteria:

- ☐ I am a current member of FOP Australia (NB: People with FOP are eligible for free lifetime membership of FOP Australia upon completion of an annual membership form). Forms available at [fopaustalia.org/join](http://fopaustalia.org/join)
- ☐ I agree to provide proof of the above information if required to the returning officer.
- ☐ I understand that each individual can only be eligible for one FOP Australia support grant every 2 years. I understand that each individual can only be eligible for one FOP Australia support for the purpose of international travel every 5 years.
- ☐ If successful, I agree to provide an invoice from the vendor to the returning officer for payment by FOP Australia (or, if this is impractical for the proposed use of funds to be guided by the returning officer regarding alternative means of confirming use of funds as proposed above).
- ☐ I confirm that all information in this application is true, and understand that if information included is incomplete or found to be false, the application will not be accepted, and FOP Australia may request refund of any funds awarded.

I have read and agree to the terms of reference for the FOP Australia support grant program.

Signature:

Name (print):

OFFICE USE ONLY: Application number:



### Application details

Please circle the relevant criteria:

I have FOP

I am a direct caregiver for someone with FOP.

I am applying for \$\_\_\_\_\_ (maximum \$1000)

**For the purpose of:**

The this will improve my life (*or for caregivers: the life of the person I care for with FOP*) because:

**Costs:** (attach further pages if more rows are necessary)

Item	Cost	Vendor

Please include a quote or invoice from the product/service suppliers (this must be valid for a minimum of three months from the time of the application closing date).

Any additional costs not included in the original application will not be covered by FOP Australia.

**Please ensure all sections are completed before sending form to [info@fopaustralia.org](mailto:info@fopaustralia.org) with subject heading: CONFIDENTIAL Grant Application.**

OFFICE USE ONLY: Application number: