GRANT APPLICATION FORM

NAME OF APPLICANT: _____

NAME OF CHILD: _____

RELATIONSHIP: PARENT / LEGAL GUARDIAN (please select) AGE OF CHILD: _____

ADDRESS: _____

_____

EMAIL ADDRESS: _____

REASON FOR GRANT (please give as much information as possible): _____

_____

_____

_____

_____

SUPPORT REQUESTED:

GRANT £1000 and FOOD VOUCHER £150: Desired supermarket: _____

BANK DETAILS:

ACCOUNT NAME: _____

ACCOUNT NUMBER: _____ SORT CODE: _____

Please complete the following in order for us to comply with GDPR regulations:

I/We agree that the information given in this form is correct.

I/We give permission for Elsie's Rose to discuss our request with the healthcare team providing support at the hospital / hospice named below.

SIGNATURE: _____ DATE: ____/____/____

SIGNING ON BEHALF:_____DATE:____/____/_____

PROFESSIONAL'S DETAILS:

NAME: _____

EMAIL ADDRESS:_____

HOSPITAL/HOSPICE: _____

I confirm the child named above is receiving end of life care at the above named hospital / hospice.

I confirm the child named above passed away within the last three months of the date of this application.

SIGNATURE: _____ DATE: ____/____/____