

Application form to request a Patient Support Grant

Please complete this form clearly in black ink

Completed forms should be returned to: Kidney Cancer UK, Abington Park Farm, Great Abington, CB21 6AX

Charity reference (office use only) _____

You can call the office on 01223 870008 or email office1@kcuk.org.uk if you have any queries.

Part 1 About you	
Title	
Surname	
Forename	
Other names	
Date of Birth	
Address	
Post code:	
Daytime Phone no.	
Evening Phone No.	
Email	

By signing this form you:

- Agree to us recording your details on our database, so we can provide you with the best possible support every time you contact us.
- Confirm you have consent from members of your household to provide the information given by you in Part 3 of this form.

We may also contact you from time to time by phone, email or post to tell you about how we can support you, Charity news, fundraising and events. Your details will be kept securely and will not be shared with third parties unless we contact you for consent to do so.

Please tick here if you do want us to use your information to keep you up to date with Charity News

Signature

Date:

The form can be signed on behalf of the patient if you have power of attorney, parental responsibility or you are the patient's legal guardian.

Full name

Capacity

Note to applicant: please contact us if these requirements will cause difficulties for your patient.

Part 2 Medical report or About your Condition

We award grants in accordance with our agreed medical criteria, which is why we need the medical information requested.

Date diagnosed with kidney cancer _____/_____/_____

Name of hospital where you have received or are receiving treatment

Consultant's Name

Hospital & Unit Address

Post code	
Your GP's Name	
Surgery Address	

In helping to assess my application, I consent to you contacting, if required further information on my medical condition.

Signed:

The next part of this section needs to be completed by a clinical nurse specialist, hospital doctor, or GP who is involved with the patient's treatment or care.

Does the above-named person have a cancer diagnosis?	Yes <input type="radio"/>	No <input type="radio"/>
Are they aware of the diagnosis?	Yes <input type="radio"/>	No <input type="radio"/>
Are they aware of the prognosis?	Yes <input type="radio"/>	No <input type="radio"/>
Is cancer treatment still being received?	Yes <input type="radio"/>	No <input type="radio"/>
If yes, what treatment is being received?		

What impact has cancer its treatment had on this person's experience of daily living?

If no disease is currently present, is there any resultant permanent disability?

Yes No

If yes, please specify:

Full Name of Medical Signatory:

Official Capacity:

Address:

Signature:

Date:

Please note unfortunately, we are not able to pay a fee for completing this medical report. This is to enable us to help as many people as possible.

Part 3 Financial & Household Information

We may ask for documentation to support the amounts given below, and we may need to request additional financial information in order to process this application.

Savings and investments (Total for household) If nil please state

Patient's financial details (please provide weekly or monthly figures- or state period)

	Weekly	Monthly
Current wages (after tax & NI deductions)	£	£
State Retirement Pension	£	£
Pension Credit	£	£
Other pensions e.g. occupational	£	£
Statutory Sick Pay	£	£

Child Benefit	£	£
Employment & Support Allowance (ESA)	£	£
Universal Credit	£	£
Income Support	£	£
Tax Credits	£	£
Other income (please specify below)	£	£
	£	£

The following benefits are not included in our financial calculations but must be stated.

Attendance Allowance	£	£
Disability Allowance (DLA)	£	£
Personal Independent Payment (PIP)	£	£
Housing Benefit	£	£

Details of all other household members

Name	Age	Weekly Income	Monthly income	Relationship to patient	Please state if income includes Attendance Allowance, DLA or PIP
		£	£		
		£	£		
		£	£		
		£	£		

Outgoings (Please note we can only take the following outgoings into consideration)

	Weekly	Monthly
Mortgage	£	£
Rent (after Housing Benefit deducted)	£	£
Council Tax	£	£

Has Housing Benefit been applied for? Yes No

Has Council Tax Support been applied for? Yes No

Property Type (please indicate) Owner occupied

- Rented from Housing Association
 Shared Ownership
 Privately rented
 Rented from local council

Occupation (Occupational benevolent funds are a potential source of financial help)

	Current Occupation	Previous Occupation
Patient		
Partner (if applicable)		

Energy/Utility Costs

We may be able to identify further help for you from fuel providers. Please state the names of your suppliers and your average fuel costs.

	Monthly Cost	Arrears	
Name of Gas Supplier:	£	Yes <input type="radio"/>	No <input type="radio"/>
Name of Electricity Supplier:	£	Yes <input type="radio"/>	No <input type="radio"/>
Name of Water Supplier:	£	Do you have a water meter? Yes <input type="radio"/> No <input type="radio"/>	

Part 4 Summary of request or About your application

Amount of Grant applied for £

Proposed purpose of Grant being applied for *(please use a separate continuation sheet if necessary)*

Apart from this application, has an application been made on behalf of the patient named for assistance from other charities or professional bodies?

Yes No

If yes, please provide further details...

Signed

Date

Part 4 Supporting explanation for request

To be completed by someone that knows you well and is prepared to support your application, as it is possible we may contact them directly. They maybe a health or social care professional, such as a nurse, GP, social worker, police officer or solicitor, not the patient or a family member.

Surname

Forename

Occupation

Address

Post Code

Contact telephone

Email

I have known the person named on this application for _____ months _____ years

I, _____ agree to endorse this application made by _____ and acknowledge that in signing this endorsement Kidney Cancer UK or Scotland may wish to contact me directly.

Please briefly explain how the need(s) identified in this application have arisen, how they are connected to the impact of cancer and its treatment and how the requested assistance will benefit your client.

Our patient grants are not a replacement for statutory benefits. However, a grant may be given if the patient is waiting for benefits to come through or if there are exceptional circumstances, so please explain this.

Help can be provided for a wide range of items or services. If requesting help towards:

- Hospital fares; Please advise us of treatment or visiting dates, the number of visits per week, the number of weeks in the treatment period and an estimate of the mileage or actual cost of each journey. Full use must be made of reimbursement through the Healthcare Travel Costs Scheme for people who are eligible.
- Convalescent Holidays;
- Household bills & appliances; Please explain why the appliance is necessary, given the impact of your client's condition.

Please write clearly or attach a typed report



Signed by _____ Date _____



Terms & Conditions of the Patient Support Grant

Patient Support Grant applications are reviewed initially by an independent committee whose names appear on the Kidney Cancer UK's website, www.kcuk.org.uk

1. Any Grant awarded will not exceed £1,000.
2. The Charity at its sole discretion reserves the right to question the applicant on the information provided and request further detail from the person endorsing the application. Whether by way of a telephone enquiry or written communication.
3. The Charity will not award a Grant to cover the cost of any medication or hospital treatment of any description, or to reduce financial debts, other than considering hardship in meeting utility bills.
4. Only one award per household will be made in any given 12-month period for a maximum of three consecutive years.
5. The Charity cannot accept any responsibility whatsoever for an application lost or delayed by any mail delivery service.
6. The money awarded needs to be used for the sole purpose for which the application was made. Kidney Cancer UK or Kidney Cancer Scotland will need to be notified in writing should the purpose change.
7. On confirmation of the awarding of a Grant all payments, where possible, will be made directly to the supplier of the service by Kidney Cancer UK or Kidney Cancer Scotland. Should this not be practical the claimant will be required to provide Kidney Cancer UK with either the originals, or copies of all documents to support the expenditure.
8. Kidney Cancer UK or Kidney Cancer Scotland will report to the relevant authorities if it suspects that there have been any attempts made to obtain a Grant in a fraudulent manner.
9. Following the awarding of a Grant the Charity will not, without written consent, use the applicant's details for any publicity or show details within any printed matter or online.
10. We will include, but will not show individual detail, the total sum of money made available under our Patient Grant scheme in the Charity's annual report and accounts. The applicant may however share information about the Grant with any parties of their choice.
11. The Charity will not enter into any verbal or written discussions should it decide not award a Grant, other than to notify the applicant that they have been unsuccessful.
12. The Kidney Cancer UK Panel's decision is final and not subject to appeal.
13. All applicants must reside in the United Kingdom.
14. The Charity will retain within its secured database details of all Grant applications made. Such information will not be disclosed to any third party unless a request is made by an authority entitled to demand the information from the Charity.

All applicants must be aged 18 years or above.

