

For Office Use Only
Application No: KP



Kidney Research UK

Application for a Kidney Patient Support Grant

Please complete all sections in clear black print/type and forward completed application Form (together with a supporting letter from the Social Worker or Renal Nurse)

PLEASE NOTE THAT ALL CATEGORIES SHOULD BE COMPLETED IN FULL AND ALL FIGURES FOR INCOME AND EXPENDITURE SHOULD BE DECLARED.

Individual Application	Application Supported by
<p>Title: Mr/Mrs/Miss/Ms</p> <p>Surname:</p> <p>Forenames:</p> <p>DOB:</p> <p>Address:</p> <p>Telephone No:</p>	<p>Name:</p> <p>Address:</p> <p>Telephone No:</p> <p>Fax No:</p> <p>E-mail Address:</p> <p>Position Held:</p>
Applicant's personal details	
<p>Marital Status: (Tick as appropriate category)</p> <p>Married <input type="checkbox"/> Single <input type="checkbox"/></p> <p>Widowed <input type="checkbox"/> Divorced /Separated <input type="checkbox"/></p> <p>Employment Status:</p> <p><input type="checkbox"/> Employed Unemployed <input type="checkbox"/></p> <p>Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/></p> <p>other: _____</p>	<p>(Tick as appropriate category)</p> <p>Own Home <input type="checkbox"/> Rented <input type="checkbox"/> Council <input type="checkbox"/></p> <p>Living with Parents <input type="checkbox"/> Other: _____</p> <p>No. of Dependants:</p> <p>Dependant Details:</p>
Please give FULL MONTHLY breakdown figures of the following:	
Applicant's Gross Income	Family Gross Income (coming to same address)
<p>Salary: £</p> <p>Incapacity Benefit: £</p> <p>Disability Living Allowance: £</p> <p>Higher Rate <input type="checkbox"/> Middle Rate <input type="checkbox"/> Lower Rate <input type="checkbox"/></p> <p>Income Support: £</p> <p>Pension/Pension Credit/Private: £</p> <p>Savings: £</p> <p>Other:</p>	<p>Salary: £</p> <p>Incapacity Benefit: £</p> <p>Income Support: £</p> <p>Carer's Allowance: £</p> <p>Pension/Pension Credit/Private: £</p> <p>Other:</p>

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PLEASE COMPLETE ALL SECTIONS IN CLEAR BLACK PRINT/TYPE

Applicant's Monthly Expenditure, (including family expenditure if applicable)		
Rent/Mortgage:	Housekeeping:	
Electricity:	Petrol:	
Gas:	Insurance:	
Water:	TV Licence:	
Council Tax:	Clothing:	
Telephone:	Other:	
Have the following sources of funding been applied to (please tick accordingly): <i>Renal patients, if unable to work, on benefits may apply to The Social Fund. The Department of Work and Pensions operate this fund which comprises of::</i>		
Community Care Grant <input type="checkbox"/>	Budgeting Loans <input type="checkbox"/>	Crisis Loans <input type="checkbox"/>
Other _____ (please state)	Not Applicable <input type="checkbox"/>	
Please state why the applicant is not entitled to public funds or hasn't applied to other sources of funding for this request: THIS SECTION MUST BE COMPLETED		
Brief Applicant's medical details: (Please give full details in the letter of support)		
Please select one of the following:		
Dialysis Patient <input type="checkbox"/>	Starting Dialysis within 3 months <input type="checkbox"/>	
Transplant patient <input type="checkbox"/>	(please state no of month/years since transplant_____)	
eGFR less than 15 <input type="checkbox"/>		
Other <input type="checkbox"/>	(Please state other medical problems below)	
Details of Request/Item:		
Reason why there is a need for the grant:		
Amount Requested:		
Estimates/Quotes/Copy Invoices attached: Yes/No (please note: if quotes are not attached this may delay your application)		

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Have you applied elsewhere for a grant: Yes/No (if yes, please give detail below):	
Organisation applied to:	
Item requested:	Outcome:
Have you received a grant from us in the past: Yes/No (if yes, please give detail below):	
What was awarded:	
Date:	
If successful, grant to be made payable to: (i.e. the provider of services/shop/or fund at the hospital, please note any grants awarded cannot be made payable to the applicant)	
Name:	
Address:	
Where did you hear about the Kidney Research UK Kidney Patient Grant Scheme:	
1) Social Worker/Renal Nurse: <input type="checkbox"/>	3) Word of mouth/Other patients: <input type="checkbox"/>
2) Leaflet/Literature: <input type="checkbox"/>	4) Other, please state <input type="checkbox"/>
Do we have your permission to use your details as a case study for insertion in our publications such as the Patients Leaflets for promotional purposes? Yes <input type="checkbox"/> No <input type="checkbox"/> (You will be contacted before any publication is produced) (this will not influence the outcome of your application)	
<h3>Declaration</h3>	
I have read the Kidney Research UK Guidelines. Yes <input type="checkbox"/> No <input type="checkbox"/>	
I give my permission for The Kidney Research UK to retain personal details as provided by me, including that of a medical or social nature.	
I confirm that the details provided in support of this application are correct to the best of my knowledge and I take responsibility for ensuring the grant will be used for the purpose stated and will not reduce any entitlement to public funds.	
I understand that all information, including medical history as provided by me will be held on Kidney Research UK's database in strict confidence and will not be used for any purpose other than to assist Kidney Research UK with assessing my application for a Kidney Patient Support Grant.	
I understand that the information will not be given to any other persons or organisations, with the exception where it is necessary for Kidney Research UK to disclose only my Name, Address and Telephone number to a reputable third party to facilitate the delivery of the requested item(s) in the event that my application is	

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successful.

The keeping of the information will conform to the requirements of the Data Protection Act 1998.

I understand that I can, at any time and upon payment of the prescribed fee, request in writing to inspect any information held about myself by Kidney Research UK, or ask to have my details removed from their files once my application has been processed.

Applicant: Name: (capital) _____ (Parent/legal guardian of child under 16)

Signature: _____ Date: _____

Sponsor: Name: (capital) _____ (named person on page 1)

Signature: _____ Date: _____

Please note that if any of the requirements are incomplete this could delay your application or your application could be refused. Therefore please ensure the following are attached:

- Detailed Supporting Letter Attached
- Quotes Attached
- All sections of form completed

Forward you're complete Form together with supporting documents to:

Grant Administration Tel: 01733 367837
Kidney Patient Support Grants Fax: 08456 047211
Kidney Research UK E-mail: grants@kidneyresearchuk.org
Nene Hall
Lynch Wood Park
Peterborough PE2 6FZ

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CM1	CM2	CM3	CM4	CM5	CM6	CM7	TOTAL (7)

Grant Approved: YES / NO Date Successful:

Issues:

Amount Awarded:

Raised – PO / Chq

Signature: