Marie Keating FOUNDATION

Comfort Fund Application

This document is strictly private and confidential. **PLEASE PRINT IN BLOCK CAPITALS**

Patient Name		Patient age	
Patient address			
Cheque/ E – payment to:		Patient email:	

✓Patient is: Complete for parent if patient is minor	Employed		Unemployed		Specify any income/benefits and weekly/monthly amount:
	Self-Employed		Retired		
✓The patient's partner	Employed		Unemployed		Not applicable
	Self-Employed		Retired		Specify any income/benefits and weekly/monthly amount:

Number of dependents living in the house under the age of 18. Please list ages.	Number	Ages

Children's Allowance Yes/No	Specify Amount €

✓Patient's living arrangements	Lives with partner	Lives alone	Lives with parents

Type of cancer	Date of diagnosis	Treatment centre

Treatment type	Surgery / Radiotherapy / Chemotherapy/ Other

Continued overleaf…..

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It is essential to give details on what the Comfort Fund grant would be used for (household bill/ childcare / travel.) Expense type and specific amount is required for each. Attach copies of bills if possible.	Total amount requested €_____

Hospital Name and address				
Contact name		Tel ( )		
Contact email addresses				
✓Does the patient have private health insurance	Yes		No	
✓Does the patient have a medical card	Yes		No	
✓Has the patient applied for/received funding from social welfare?	Yes		No	
✓Has the patient applied for /received funding from other organisations (E.g. Travel 2 Care) in relation to this request	Yes		No	

If yes, please give details i.e. amount granted and amount (if any) outstanding	
If there is any additional information available in support of this application, please give specific details here:	

***Please note**: it is vital that the bills/ expenses detailed are outstanding or anticipated and that evidence is provided in order for this application to be considered. Only one grant can be provided per patient.*

Signatures:

Patient: _____ Print Name _____ Date _____

HCP: _____ Print Name _____ Date _____

Authorisation (Internal Use Only) Date:	Initial:	Amount:	Reference:	Process:	

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Return completed forms by post to:
Helen Forristal, Director of Nursing Services, Marie Keating Foundation, Unit 9, Millbank Business Park, Lucan, K78A292

Payment – (mark as appropriate)
Pay directly to account OR ☐ Cheque to Patient OR ☐ Cheque to Social Worker ☐

Please supply bank details for payment into account:

Account Name

IBAN

BIC

Bank Name

Bank Address