Comfort Fund Application

This document is strictly private and confidential.

Please note that the Comfort Fund is a **ONCE OFF ONLY** financial grant for those currently receiving treatment for cancer

Comfort Fund applications will **ONLY** be accepted when filled out completely by a Health Care Professional (HCP)

Patient Name:

Patient DOB: / /

Patient Address:

Patient Email:

Phone Number:

Please indicate the category that best fits your applicant's status

Patient is:

Employed ○ Unemployed ○ Self-employed ○ Retired ○

Full time: ☐ Receiving social welfare ☐

Part Time: ☐

Please specify the amount received in weekly/monthly income/benefits:

Patient's partner is:

Employed ○ Unemployed ○ Self-employed ○ Retired ○ NA ○

Full time: ☐ Receiving social welfare ☐

Part Time: ☐

Please specify the amount received in weekly/monthly income/benefits:

Any other contributing household member/s (please list number of adults contributing):

Yes ○ No ○ If so, please specify amount contributed:

Number of dependents living in the house under the age of 18 (please list ages below):

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Do you receive children's allowance:

Yes ○ No ○ If so, please specify amount received:

Patient's living arrangements:

Lives with partner ○ Lives Alone ○ Lives with parents ○ Other ○ If other, please specify:

Please fill in the relevant information below:

Type of Cancer:

Date of Diagnosis:

Treatment Centre:

Treatment Type:

Surgery ○ Radiotherapy ○ Chemotherapy ○ Other ○

Treating Hospital:

Name:

Address:

HCP (Health Care Professional completing the form) Details:

Name:

Phone Number:

Email Address:

Does the patient have private health insurance?: Yes ○ No ○

Does this insurance cover the cost of treatment?: Yes ○ No ○

Does the patient have a medical card?: Yes ○ No ○

Does the patient have a Drug Payment Scheme?: Yes ○ No ○

Is the patient receiving funding from other charities?: Yes ○ No ○

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I, the HCP completing this application, confirm that I have seen/received the relevant receipts/expenses on behalf of this applicant and believe them to be an acceptable candidate for the Comfort Fund:

HCP Signature:

Amount Requested:

Additional information in support of this application is mandatory. Please provide specific details of financial needs for the last three months in this section.

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I confirm that the expenses/bills have been validated by the HCP and all expenses provided are current:

I acknowledge that submission of this application does not guarantee payment of a Comfort Fund grant by MKF:

Signatures:

I, the HCP have consent to submit this application on behalf of the patient named above:

HCP Signature: _____ Date: _____
(completing the form)

Due to the high demand for The Comfort Fund Grant and the Marie Keating Foundation's limited resources, this application will be reviewed and assessed and financial grants will be awarded on a case by case basis

For Internal Use only: Authorisation

Amount:	Inital:	Reference:	Process:

Payment Information

Please provide details to pay directly into bank account:

Account Name:

IBAN:

BIC:

In exceptional cases where a bank payment is not possible, please tick the box*

**By ticking the box above, the HCP completing this form consents to being contacted by an MKF team member to make alternative payment arrangements for your applicant*

All personal details will be permanently deleted once the grant has been processed.