

Application Pack



Caring Hearts

Supporting Sick & Disabled Children

Charity Registration Number: 1114140

Registered Address:

15 Bellevue Place, Southend-On-Sea,
Essex, SS1 2RA

Tel: 01702 435666 Fax: 01702 437344

Email: caringhearts@tiscali.co.uk

Grants Address:

1-3 Station Hill House, Station Hill, Chippenham,
Wiltshire, SN15 1EQ

Tel: 01249 656112 Fax: 01249 656425

Email: caringhearts@tiscali.co.uk

Trustees: Ms Caroline Walker, Ms Lysanne Allen, Miss Linda Grimmer Also a Company Limited by Guarantee No: 05628170

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Application Pack Notes

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- 1 If you need to contact us about your application at any time, please use the Chippenham Grants Office Number : 01249 656112

 - 2 All sections of the Application Form must be completed and be honest and truthful at the time of completion.

If the child's circumstances change you must notify Caring Hearts immediately.

 - 3 Please note that although you can list three wishes / areas of support, Caring Hearts may only grant one of these.

 - 4 Please provide us with a photograph of the child. This helps us put a face to the name and makes it more personal.

 - 5 Make sure that the qualified medical practitioners responsible for the primary care of the child feel that any support / wishes applied for are suitable and beneficial to the child.

 - 6 Any funds raised to enable the child's wish to be granted that is over and above that required will be used for other worthy causes.

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A) Background Information

Who is completing the form on behalf of the child?
Parent / Guardian GP Other (please specify):

Childs Name: Gender:

Date of Birth: Age:

Address:

Mothers Name:

Fathers Name:

Parent(s) Phone Numbers - Home: Mobile:

Parent(s) Email Address:

Does the child live at the above address with both parents? Yes No

If no, which parent lives at the above address with the child?

B) Medical Details

(If you need more space to include further details to the following questions please complete overleaf)

Childs Illness / Disability:

Date first diagnosed?

Are you aware of the prognosis? Yes No *(If yes please provide details below)*

Is the child fully aware of their condition? Yes No

Main Specialist

Name: Job Title:

Address:

Phone Number: Fax Number:

Email Address:

GP

Name: Practice Name:

Address:

Phone Number: Fax Number:

Email Address:

Social Worker if Applicable

Name:

Address:

Phone Number: Fax Number:

Email Address:

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C) Support / Wish Funds Applied For

Please note that Caring Hearts only grant wishes to support sick and disabled children under the age of 18.

Has your child ever applied for support from any other organisation? Yes No
NB: Failure to disclose this information may result in your child's application being turned down.

Was the support granted? Yes No

If yes please state:

- a) The name of the organisation? _____
b) A description of the support / wish provided for:

Please list your child's top three support or wish requirements in order of preference including complete details - continue overleaf if necessary.

Please note that we may only be able to provide for one of these.

1)

2)

3)

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E) Publicity

Publicity is obviously hugely helpful to all charities in order to raise funds to help others and make wishes come true.

With this in mind we would like to ask for your approval to create general media coverage in order to fulfil your child's request for support / wishes.

This may involve the use of photographs or the publication of brief details for promotional use in order to raise public awareness and funds.

Your consent can always be withdrawn and your decision will not affect your application.

Yes I consent to you generating publicity []

Sorry but I'd rather not have any publicity []

Parent / Guardian Signature

Please Print Name

Date

To be Completed by the Parent or Guardian of the Child

I declare to the best of my knowledge that I have completed this form as truthfully and accurately as I can as of this date, and confirm that if I become aware of any changes of circumstances in relation to this application or changes in the child's condition that I will notify Caring Hearts immediately.

Parent / Guardian Signature

Please Print Name

Date

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F) Medical Consent

(to be completed by the Consultant primarily responsible for the medical care and supervision of the child)

Name & Title: _____

Job Title: _____

Place of Work & Address: _____

Your Diagnosis of the Childs Medical Circumstances: _____

Explanation, Details, Consequences & Outcomes of Diagnosis: _____

Can you confirm that the replies given to questions regarding Medical Information within this Application Pack are correct?

Yes No _____

Can you confirm that the requested support / wish should have no adverse effect upon the child?

Yes No _____

Would you recommend that the child participates in one or more of the areas of support / wishes requested within this pack?

Yes No _____

Signed: _____

Print Name: _____

Address: _____

Tel. No.: _____

Fax No.: _____

Email: _____

Dated: _____

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