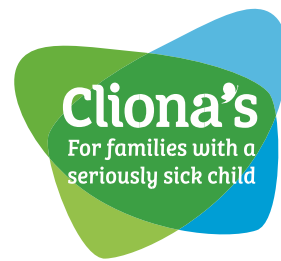


Application Form for Financial Support (for children from birth to 16 years of age)

**ALL SECTIONS MUST BE COMPLETED OR FORM WILL BE**

**RETURNED**



Parents/Guardians Names: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Eircode : \_\_\_\_\_

Email Address **(required)** \_\_\_\_\_

**Contact Number** (Mobile) \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship of applicant to child: \_\_\_\_\_

Brief details of Child's illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was the illness first diagnosed? \_\_\_\_\_

Why do you need financial support? \_\_\_\_\_

\_\_\_\_\_

**Bank Details (to receive funding if approved)**

Name on Account \_\_\_\_\_

IBAN NO. \_\_\_\_\_

NAME & ADDRESS OF BANK \_\_\_\_\_

Have you applied for funding from Cliona's Foundation in the past?

Yes  No  if yes, when? \_\_\_\_\_

Have you approached any other organisation for funding?

Yes  No

If yes, please give brief details:

\_\_\_\_\_

Is there any other support you could benefit from? i.e Support groups, counselling.

\_\_\_\_\_

**Employment Status**

Mother Employed Yes  No

Father Employed Yes  No

**Medical Details**

Name of Specialist / Consultant: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Signed (by individual completing application form)

Date: \_\_\_\_\_

**Original letter of support, on a letterhead, currently dated and addressed to Cliona's from your Specialist or Consultant AND your Medical Social Worker or Nurse Practioner/Home Support Nurse, must be attached.**

**PARENT/GUARDIAN SIGNATURE**

**In the event of receiving financial assistance would you be willing to share your situation & publicise your child's details on our literature/website as a means of creating awareness & raising additional funds for other families?**

Yes  No

**Please forward application form & Support letter to: Cliona's Foundation  
Unit 22 Groody Centre, Castletroy,  
Limerick, V94 YA07**