IBN Charitable Foundation

Health

IBN

Freecall 1800 014 401

1. First name

2. Last name

3. Date of birth / / Vehicle registration number

4. Language group (tick one box only)
☐ Yinhawangka ☐ Banyjima ☐ Nyiyaparli

5. Postal address

6. Phone
( )

7. Email address

8. How do you prefer to be contacted?
☐ Phone ☐ Email ☐ Postal address

9. Do you receive Family Payments for any children?
No ☐
Yes ☐ ▶ For how many children?

10. Do you have a current Centrelink Pension card or Health Care card?
No ☐ Yes ☐ ▶ Please provide the card number and expiry date
  / /

11. Have you received financial assistance from any other trust(s) within the past three months?
No ☐ Yes ☐ ▶ Please tell us how much you received

Name of organisation	Amount

12. IBN provides health funding under a number of different categories. Which of the following categories best describes the expenses you need help with?
☐ Dental (general dental expenses)
☐ Community Health (skip bins, animal desexing, other veterinary costs)
☐ Critically-ill Patient Support
☐ General Health (all other general or basic health expenses)

Please be aware that we may ask you for a letter from your doctor to support your request for help.

13. Expenses requested

Please attach bills, quotes or other documents to help IBN assess your application.

Description (What is the money for?)	Name of supplier (Who is being paid?)	Amount required
Example: Specialist visit	Dr Bloggs	$400.00

Returning this form ▶
Post: PO Box 2390 South Hedland WA 6722
Fax: (08) 9172 1136
Email: applications@ibngroup.com.au

In person: 3 Brand Street, South Hedland • 973 Central Road, Tom Price • 7/18 Hedland Place, Karratha.

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14 What unexpected event(s) has happened recently that has caused you to ask for help?

Please attach any paperwork that helps explain why you are in financial hardship.

15 Is any of this money for a child in your care?

No ☐

Yes ☐ Please provide the details of each child who will benefit from the money

Name		Date of birth	/ /
Name		Date of birth	/ /
Name		Date of birth	/ /
Name		Date of birth	/ /
Name		Date of birth	/ /
Name		Date of birth	/ /

16 Please explain how this will help to improve yours or your community's health and wellbeing.

17 I declare that the above information is true and the assistance requested is for my own use or for my child's/children/ dependent's use. I agree to my information being shared with or checked by other organisations for application assessment purposes.

Signature 7 Date / /

Office use only

Date received / / Received by

CP#

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