IBN Charitable Foundation

Elderly, Disabled and Infirm

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 ☐ Nyiyarparli

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 Do you have a carer?

No ☐

Yes ☐ ▶ Please provide your carer's name

Carer's contact phone number ( )

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: Mobility scooter	Mobility Equipment Australia	$2,000.00

14 Please provide details about any medical condition(s) you may have

▶ Additional space on next page.

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.

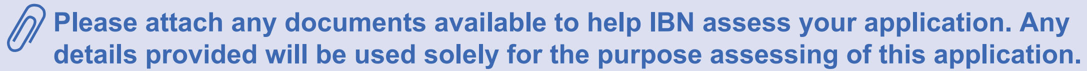
14 Continued

15 Are you receiving treatment for this condition(s)?

No ☐
Yes ☐ ▶ Please provide details of the treatment

16 Is there any medical information you can attach to support your application?

No ☐
Yes ☐


Please attach any documents available to help IBN assess your application. Any details provided will be used solely for the purpose assessing of this application.

17 Does your medical condition affect your ability to function normally?

No ☐
Yes ☐ ▶ Please provide details of how the condition affects your day-to-day activities

18 How will assistance from IBN improve your health / wellbeing?

19 I declare that the above information is true and the assistance requested is for my own 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#

IBN Corporation Pty Ltd
ACN 093 140 240

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