IBN Charitable Foundation

2.0 Health and Wellbeing: General Health / Dental Health / Other

1 First name

2 Last name

3 Date of birth

/ /

4 Language group (tick one box only)

☐ Yinhawangka ☐ Banyjima ☐ Nyiyaparli

5 Residential address *(this must be your registered address with IBN)*

If this not your registered address with IBN you will need to complete the Update Personal Details form before we can process your application

6 Phone

( )

7 Email address

8 Do you have private health insurance?

No ☐ Yes ☐ If yes, please attach a copy of your insurance cover

9 How do you prefer to be contacted?

☐ Phone ☐ Email ☐ Postal address

10 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

11 IBN provides Health and Wellbeing funding under a number of different categories. Which of the following categories best describes the expenses you need help with?

☐ General Health ☐ Dental Health ☐ Skip bins

☐ Bottled / filtered water ☐ Veterinary expenses

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

Please attach paperwork to help IBN assess your application such as treatment plan, letter from your doctor, bills, or quotes.

12 Expenses requested

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) 9140 0998
Email: applications@ibngroup.com.au

In person delivered to: 3 Brand Street, South Hedland, 973 Central Road, Tom Price or 3/4 Welcome Road, Karratha

13 Have you applied for PATS?

No ☐ Yes ☐ If not, please explain why

14 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	/ /

15 Optional: Please tell us how this will improve yours/ your family's health and well-being.

16 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 ✗ Date / /

Office use only

Date received / /

Received by

IBN Corporation Pty Ltd
ACN 093 140 240

CP#

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