**DAMON COURTENAY MEMORIAL ENDOWMENT FUND**

**(DCMEF)**

**GRANT APPLICATION FORM**

1. **NAME OF APPLICANT**
2. **ADDRESS**

**TELEPHONE**       **EMAIL**

1. **NAME OF PERSON WHO WILL BENEFIT FROM THE GRANT (*If not the applicant*)**

1. **AGE OF PERSON WHO WILL BENEFIT**

1. **ADDRESS OF THE PERSON WHO WILL BENEFIT**

**TELEPHONE**       **EMAIL**

 ***(please note that this person may be contacted if not the applicant)***

1. **Does the person to benefit from the grant have a bleeding disorder?**

**Yes / No**

1. **Contact detAILS OF AN INDEPENDENT PERSON SUCH AS A HEALTH PROFESSIONAL AT YOUR HAEMOPHILIA TREATMENT CENTRE TO VERIFY THAT THE APPLICANT OR THE PERSON TO BENEFIT FROM THE GRANT HAS A BLEEDING DISORDER**

**NAME**

**TELEPHONE**

**EMAIL**

1. **PLEASE PROVIDE FURTHER DETAILS OF HOW THE BLEEDING DISORDER AFFECTS THE PERSON**

1. **WHAT WILL THE GRANT BE USED FOR*? (describe the project or activity in detail – add a further page if necessary)***

1. **OUTLINE HOW THIS GRANT WILL BENEFIT THE PERSON WHO RECEIVE THE GRANT?**

1. **HOW MUCH IS REQUESTED FROM DCMEF? $**
2. **WHAT IS THE TOTAL COST FOR THE PROJECT/ACTIVITY?**

***(Attach quotes or other evidence of the likely costs if you have them)***

**$**

1. **WHEN IS ACTIVITY LIKELY TO START AND FINISH?**

1. **HAVE YOU REQUESTED FUNDS FROM OTHER SOURCES FOR THIS PROJECT/PURPOSE?**

**Yes / No**

**IF ‘YES’ PLEASE INDICATE HOW MUCH WAS REQUESTED AND WHETHER THIS REQUEST WAS SUCCESSFUL:**

$

 **SUCCESSFUL? Yes / No**

**IF YOU ALREADY HAVE RECEIVED OTHER FUNDS, OR HAVE YOUR OWN TO CONTRIBUTE, PLEASE SPECIFY THE AMOUNT $**

**OR**

**WHEN WILL YOU KNOW THE OUTCOME OF THE OTHER APPLICATIONS?**

1. **WILL THE PROJECT/ACTIVITY GO AHEAD IF FUNDING FROM DCMEF IS NOT GRANTED?**

**Yes / No**

1. **DO YOU AGREE TO PROVIDE A REPORT ON THE OUTCOME OF THE ACTIVITY UNDERTAKEN WITH THE GRANT TO HFA?**

**Yes / No**

1. **PLEASE ATTACH A WRITTEN REFERENCE FROM AN INDEPENDENT PERSON TO SUPPORT YOUR APPLICATION OR PROVIDE THEIR CONTACT DETAILS SO THAT HFA CAN FOLLOW UP. THIS PERSON MUST NOT BE A RELATIVE OR A FRIEND – IT COULD BE A TREATING HEALTH PROFESSIONAL OR A TEACHER, FOR EAMPLE**

1. **PLEASE LIST ANY OTHER COMMENTS IN SUPPORT OF YOUR APPLICATION**

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**

(Applicant)

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**

 (Person who will benefit)

**APPLICATIONS CLOSE ON 30 AUGUST 2022**

**HOW TO LODGE YOUR APPLICATION:**

By Email: hfaust@haemophilia.org.au

By Post: HFA, Post Office Box 1208, DARLING VIC 3145