Grant application form

saving the lives of people with blood cancer

Please refer to the separate 'Grant Application Advice' sheet for help on completing your grant application. The personal and medical information requested in this form will be used by Anthony Nolan to process your application. The details will not be disclosed to any other person or organisation.

Please sign below to give Anthony Nolan consent to use your data in support of this application. A representative can sign on behalf of the patient if they have power of attorney, parental responsibility or are the patient's legal guardian.

Completed application forms should be returned to:

patientgrants@anthonynolan.org

If you have any questions about completing the form, you can email **patientgrants@anthonynolan.org** or call **0303 303 0303** and ask to speak with the patient services team.

1. Patient's details*

This section can be completed by the patient or their representative.

Title _____ First Name(s) _____ Surname _____

DOB _____ Address _____

_____ Postcode _____

Phone _____

Email _____

Signature _____ Date _____

Capacity _____
(if not patient)

YOUR BANK DETAILS*

(to be used if your application is successful)

Name of account holder _____

Account no. ☐☐☐☐☐☐☐☐ Sort code ☐☐ ☐☐ ☐☐

*we cannot process your application without this information

OFFICE USE ONLY

Medical reference confirmed? Yes/No

Date received

Date of panel

Is the patient eligible for a Grant? Yes/No

Amount requested

Amount awarded

Application number

Date of follow up

Additional comments

2. Supporting explanation*

To be completed by the patient or representative. You should explain the specific needs that have arisen from, or are related to, your stem cell transplant. You should also explain how the financial help requested will help to address your identified needs.

Please provide details of the cost of items or services that you will buy or have bought in the last three months.

Please specify the items or services you are applying for. Please list in order of priority, as it may not be possible to assist with all of the items requested.

Item or service	Amount (£)
e.g. costs of new clothes, household items, or hospital travel.	£40
Total (£)	

Please tell us about the impact that this money would make for you:

*we cannot process your application without this information

3. Financial details

We may ask for documentation to support the amounts given below. We will consider applications whether or not the patient has received alternative sources of financial support.

Have you applied for an Anthony Nolan Grant before?* Yes/No

If yes, please provide further details

Have you applied for a Macmillan Grant? Yes/No

Was your application successful? Yes/No/Waiting to hear

Please provide further details

Please give a rough estimate of your accumulated savings* (if nil please state): _____

Who are these savings for? Individual/Couple/Family

Have you applied for:

Help from the Healthcare Travel Costs Scheme?* Yes/No

Assistance from other charities or professional bodies?* Yes/No

A Community Care Grant or for other benefits?* Yes/No

Please provide further details

Are you in receipt of any of the following benefits?*
(This information is not included in our decision but must be stated)

Statutory Sick Pay Yes/No

Child Benefit Yes/No

Employment & Support Allowance Yes/No

Incapacity Benefit Yes/No

Income Support Yes/No

Tax Credit Yes/No

State retirement pension Yes/No

Pension Credit Yes/No

Other pensions Yes/No

Other income (please specify) Yes/No

_____

Attendance Allowance Yes/No

Disability Living Allowance Yes/No

PIP Yes/No

Housing Benefit Yes/No

If you have applied for any of the above and are currently waiting to hear whether your application is successful, please state which ones here:

Please list your monthly outgoings in:

Mortgage* _____ Rent* _____

Council tax* _____

*we cannot process your application without this information

4. Medical report*

This section should be **completed by a doctor, nurse, or allied health professional** involved in the patient's transplant care (e.g. dietician, physiotherapist).

PATIENT'S DETAILS

Diagnosis _____ Date of diagnosis _____

Has the patient had a stem cell transplant? Yes/No

Is the patient expected to have a stem cell transplant in the next six months? Yes/No

What was the type of transplant?
(e.g. autologous, related allogeneic, unrelated allogeneic, cord) _____

Date of transplant _____

What impact has the diagnosis or transplant had on this person's experience of daily living?

Based on your knowledge of the patient's situation, why do you support this application for financial support?

HEALTH PROFESSIONAL'S DETAILS

Title _____ First name(s) _____ Surname _____

Work address _____

_____ Postcode _____

Work phone _____

Work email _____

Please note: unfortunately, we are unable to pay a fee for completing this medical report. This is so that we can help as many people as possible.

*we cannot process your application without this information

Reg charity no
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