The Equipment Grant Scheme enables people (adults and children) living with TM or related conditions, to access funding for equipment which aids in their rehabilitation, ability to self-care, and/or ability to maintain or increase independence and quality of life. If you have found a piece of equipment which is necessary for you to achieve this and require funding, please complete this application form. Refer to the ‘Equipment Grant Scheme Guidance Notes’ when completing the application (available on TMS website). The information requested enables the Transverse Myelitis Society to make a fair decision regarding the application for a grant. Please submit your completed application form via email or post to

Sally Rodohan acting Chair Transverse Myelitis Society

Email:

sally.rodohan@myelitis.org.uk

Post: Flat 1 Crathorne House Oak Lane East Finchley London N2 8LY

**ABOUT YOU (or your child)**

|  |  |
| --- | --- |
| **Name of applicant** |  |

|  |  |  |
| --- | --- | --- |
| **I am applying for an equipment grant on behalf of**  (please specify) | Myself | My child |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of child**  (if applicable) |  | **Date of Birth** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis**  (please specify TM, ADEM, NMO, ON, or related condition) |  | **Year of diagnosis** |  |

|  |  |  |
| --- | --- | --- |
| **Are you a member of the Transverse Myelitis Society?** (please specify) | Yes | This scheme is open to members of the Transverse Myelitis Society. To become a member, which is free of charge, complete the on-line application form prior to submitting your equipment grant application. - <http://membership.myelitis.org.uk/> |
| No |

**YOUR CONTACT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Address**  NOTE: This scheme is open to residents of England, Wales, Scotland and Northern Ireland. | |  | | |
| **Telephone** |  | | **Email** |  |

**EQUIPMENT YOU ARE REQUESTING FUNDING FOR**

|  |
| --- |
| **What kind of equipment are you requesting funding for?** |
|  |

|  |
| --- |
| **Please state the reasons why you (or your child) need the equipment and its proposed benefits.** |
|  |

|  |  |  |
| --- | --- | --- |
| **I have explored statutory sources of funding for this equipment.** | Yes | No |
| **Is the equipment you are requesting a grant for supplied by statutory services?** | Yes | No |
| Please check if the equipment you are requesting a grant for is supplied by statutory services. If you have applied for statutory funding for the equipment you are requesting in this application, please provide documentation demonstrating statutory decision-making as applicable. | | |

|  |  |
| --- | --- |
| **How much has the equipment cost or will cost?** Please provide cost and supplier details.  If you have already purchased the equipment, please also include a copy of receipt of purchase with the application. | |
| Actual Cost/ Quote |  |
| Supplier’s details |  |

|  |  |
| --- | --- |
| **Have you approached other organisations for funding?**  If yes, please list the organisations and the amounts available to you. If not, please state reasons why. |  |
|  |
|  |

**MEDICAL, HEALTHCARE OR SOCIAL CARE PROFESSIONAL**

This section is optional yet highly recommended as it strengthens an application. Third party confirmation from an appropriately qualified professional helps to ensure the equipment will meet your present and future needs. It can be completed by an appropriate medical, healthcare or social care professional familiar with your or your child's condition and circumstances (GP, consultant, physiotherapist, occupational therapist, neurologist, nurse or social worker). If you are unable to obtain this, please state why in the Additional Information section.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of professional** | | |  | | | | | | |
| **Role** | | |  | | | | | | |
| **Organisation** | | |  | | | | | | |
| **Address** | | |  | | | | | | |
| **City** |  | | | **County** |  | | | P**ostcode** |  |
| **Telephone** | |  | | | | **Email** |  | | |

|  |
| --- |
| **Reasons you recommend your patient/client has the requested equipment.** |
|  |

|  |  |
| --- | --- |
| **Professional’s Signature** |  |
| **Date** |  |

**ADDITIONAL INFORMATION**

If there is any additional information you would like us to know, such as any reasons why you cannot obtain independent confirmation from a medical, healthcare or social care professional; there are issues regarding financial contribution; there are issues obtaining equipment from statutory services; or if you are requesting a special case is made regarding your application as per exceptional circumstances outlined in the guidance notes, please indicate here.

|  |
| --- |
| **Anything else you would like us to know.** |
|  |

**APPLICANT’S SIGNATURE**

As the applicant, I understand that I am responsible for costs associated with assessment, installation, set-up, ongoing maintenance of, and insurance for the equipment I purchase with monies I may receive from the TMS Equipment Grant Scheme.

Please tick as appropriate.

|  |  |
| --- | --- |
|  | I have purchased the equipment within one month of making this application and have included a copy of the receipt of purchase with my application. |
|  | If my application is approved, I will purchase the equipment within one month of receiving the monies from the TMS and will provide the TMS with a copy of the receipt of purchase for its records. |

|  |  |
| --- | --- |
| **Applicant’s Signature** |  |
| **Date** |  |

CONFIDENTIALITY: All information will be treated by the Transverse Myelitis Society in confidence, but the Equipment Grant Scheme Committee reserves the right to approach your health or social care professional supporting your application for further help or information; and to use the information provided by them and in this form anonymously.