**Office use:**

Date received:

Decision & date:

Date actioned:



**MND SUPPORT (CARE) GRANT APPLICATION FORM**

**(to be completed by a Health & Social Care Professional following an assessment)**

**Please read before completing**

Motor Neurone Disease Association grants are designed to make a difference to those living with or affected by Motor Neurone Disease (MND).

Our Support (Care) Grant is predominantly for equipment or adaptations requiring professional expert assessment and by completing the form you are confirming that a full assessment has been carried out to establish the need and suitability of the item or service requested.

Funding is limited, and applications will be assessed based on need and impact. Please note that the MND Association cannot use its resources to replace statutory responsibilities, therefore for grants towards items or services where an assessment is required, evidence must be provided to confirm that statutory services provision has been investigated. Evidence must detail why provision is not available or the likely timescale where there is a delay.

We cannot always award grants at the category maximum; these amounts are a guideline only. We consider budget, value for money and impact of the grant, and may award any amount *up to* the maximum and we strongly recommend that you call our Support Services team on 0808 802 6262 for advice before submitting an application.

We aim to process applications within 10 working days of receipt of a *complete* application which includes all supporting documents.

Once a decision has been made, the applicant and the Health & Social Care Professional will be informed of the decision.

**Exclusions**

The Association will not provide a grant in the following instances:

* Equipment and adaptations that are a statutory responsibility
* Medicines/ drugs that are a statutory responsibility
* Medicines/drugs that are unproven treatments
* Retrospective funding
* Emergency healthcare needs
* Equipment for assessment for use by health and social care professionals unless with the express approval of the director or deputy director of care improvement

The Association may provide a grant in exceptional circumstances and the process is detailed in our [Support Grant Guidance](https://www.mndassociation.org/app/uploads/2022/09/Support-Grant-Guidance-September-2022.pdf) in Section 7.

Please complete the application form as fully as possible – **all questions are mandatory (see Appendix A for exception).** Ensure that all supporting documentation and information is provided as incomplete applications forms will result in the application being delayed whilst further clarification/information is requested.

The completed application form and supporting documentation can be returned by email to [support.services@mndassociation.org](mailto:support.services@mndassociation.org) or by post to: Motor Neurone Disease Association,

Francis Crick House, 6 Summerhouse Road, Moulton Park, Northampton, NN3 6BJ.

**1. DETAILS OF PERSON WITH MND**

|  |  |
| --- | --- |
| **Title** Mr/Mrs/Ms/Miss/Mx/Other/No title  **First Name**  **Surname** | **Gender**  Male  Female  Non-Binary  Trans  Other |
| Date of birth | Date of diagnosis |
| Religion (see Appendix A) | Sexual Orientation (see Appendix A) |
| NHS Number (if known) | Ethnicity (see Appendix A) |
| Address  Postcode | Preferred contact name and method for queries relating to this application: -  Name……………………………………………….  …Telephone  …Email |
| E-mail address |
| Telephone |
| GPs name and address | |
| **Work History/Professions**  Providing us with work history enables us to potentially approach and/or signpost to other charities that support people who currently, or have previously worked, in specific jobs/professions/armed forces, and may be able to help with the cost of the item/service you require.  Please list as many as applicable: - | |

**2. DETAILS OF REQUESTING PROFESSIONAL**

|  |  |
| --- | --- |
| Name of requesting professional | Job title |
| Address  Postcode | Preferred contact method for queries relating to this application: -  …Telephone  …Email  Normal working hours when you can be contacted:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E-mail |
| Telephone |
| Contact name and telephone/e-mail of a colleague who can be contacted if you are unavailable:  Name……………………………………………….  …Telephone  Email ……………………………. |

**3. DETAILS OF MND SUPPORT GRANT REQUEST**

|  |
| --- |
| I confirm a full assessment has been carried to establish the need and suitability of the specific item or service requested on this application.  **Yes No**  If **Yes** please include date of assessment …………………………  If **No** – please advise why …………………………………………………………………………….  ……………………………………………………………………………………………………………….. |
| Is the person with MND in receipt of any of the following:   * NHS Continuing Health Care Funding Yes No * Personal Health Budget Funding Yes No * Disabled Facilities Grant (DFG) Yes No * Any other Funding Yes No * If yes, please state…………………………. |
| Has an application for funding been made to statutory services?  **Yes No**  If **Yes** please enclose/include evidence of request including timescale of provision (if appropriate)  If **No** please advise why ……………………………………………………………………………………..  ……………………………………………………………………………………………………………………… |
| Is the person with MND able to part fund this item/service?  **Yes No**  If yes, what is the maximum amount they can contribute? £..................  If no, please give brief details of their circumstances:  ……………………………………………………………………………………………………………………….. |
| **Amount of support requested** (please see Appendix B for guide amounts on offered support)  **£**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Details**  Please provide full details of the support grant and include any relevant information that will help us to process the request. This includes how the grant will improve the quality of life for the person with MND and/or their carer?  **Quotations must be provided as the application will not be processed without** |

**4. PAYMENT DETAILS**

If a contribution from the MND Association is agreed, we will contact the relevant person/supplier to arrange direct payment where appropriate.

**5. STATEMENT BY THE REFERRING PROFESSIONAL**

|  |  |
| --- | --- |
| If this application is approved, I understand that, unless otherwise agreed with the Support Services team:   * Where appropriate, it is my responsibility to continue to pursue funding from statutory services. * I have undertaken due diligence and can confirm that the equipment or service for which I am applying for funding was suitable at the time of assessment. * It is the responsibility of my service to monitor and assess the ongoing needs of the person with MND in relation to this application,where clinically indicated.   I also confirm the following:-   * **All questions have been answered.** * **A quotation is enclosed.** * **Confirmation of statutory service request and outcome is included.** | |
| **Signed:** | **Date:** |

**6. DATA PROTECTION STATEMENT**

|  |  |
| --- | --- |
| Has the person with MND consented to this application and the sharing of their contact details?  **Yes**  **No**  The Association will follow procedures for recording, storing, and updating personal information all of which will comply with the Data Protection Act 1998 and any subsequent legislation including the General Data Protection Regulation.  We may occasionally share your information within the Association and with local health and social care professionals where it helps with your care and support or with development of better services.  If you have already expressed a preference for future contact we will follow these, if not, we may ask you for your views on how our services might be improved. If you do not want us to be in contact, please let us know on [support.services@mndassociation.org](mailto:support.services@mndassociation.org)  Please see our privacy policy on our website [www.mndassociation.org](https://www.mndassociation.org/) for full details of how we use your information. | |
| **Signature of person with MND:**  *(Professional can sign on person’s behalf)* | **Date:** |

**Appendix A**

This information is not mandatory and is used anonymously to help us determine to what extent different communities are and are not using our services or engaging with us and most importantly to then identify and remove barriers to participation. We are committed to becoming a fully inclusive organisation.

**Ethnicity Codes**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| A - White | English / Welsh / Scottish / N Irish / British | A01 |
|  | Irish | A02 |
|  | Traveller | A03 |
|  | Any other white background | A04 |
| B - Mixed / multiple ethnic groups | White and Black Caribbean | B01 |
|  | White and Black African | B02 |
|  | White and Asian | B03 |
|  | Any other mixed / multiple background | B04 |
| C - Asian / Asian British | Indian | C01 |
|  | Pakistani | C02 |
|  | Bangladeshi | C03 |
|  | Chinese | C04 |
|  | Any other Asian background | C05 |
| D - Black / African / Caribbean / Black British | African | D01 |
|  | Caribbean | D02 |
|  | Any other Black / African / Caribbean background | D03 |
| E - Other ethnic group | Arab | E01 |
|  | Any other ethnic group | E02 |
| F | Prefer not to say | F01 |
| Unknown |  | U01 |
| Any other |  | O01 |

|  |  |
| --- | --- |
| **Sexual Orientation** | **Religion** |
| Heterosexual | Christian |
| Lesbian | Muslim |
| Gay | Hindu |
| Bisexual | Buddhist |
| Other | Jewish |
| Prefer not to say | Atheist |
|  | Jain |
|  | Sikh |
|  | Other |
|  | Prefer not to say |

A logo for a motor neurone association

Description automatically generated

**Appendix B**

|  |  |
| --- | --- |
| **Support (Care) Grant Category** | **Guide £** |
| Adaptations | \* |
| Alarms/Telecare (purchase or rental) | £150 |
| Bed and Bed Accessories (purchase or rental) | £750 |
| Computer Access (purchase or rental) | £450 |
| Environmental Controls (purchase or rental) | £500 |
| Feeding Aid (purchase or rental) | £1000 |
| Head Support (purchase or rental) | £150 |
| Hoist/Lifting Equipment (purchase or rental) | £800 |
| Mobile Arm Support (assessment) | £580 |
| Personal Care | £500 |
| Ramps (purchase or rental) | £750 |
| Specialist Chair/Seating (purchase or rental) | £945 |
| Stairlift (Straight/curved, purchase or rental) | £1,500 |
| Stair climber (purchase) | £500 |
| Washer/Dryer WC (purchase) | £1,500 |
| Respiratory | £1000 |
| Respite Care (at home or residential) | £1000 |
| Vehicle (wheelchair accessible vehicle) | £1000 |
| Vehicle Adaptation | £1000 |

\*Case by case basis