Date application received:	…../…… /……
Trustee Meeting Considered:	…../…… /……

Therapy Grant Application Form

All fields must be completed to enable your application to be considered.

1. APPLICANTS DETAILS			
Does the person have Cerebral Palsy?	**YES / NO**	**Full Name:**	
Is this a first time application?	**YES / NO**	**Address:**	
If Yes – please enclose proof of diagnosis eg letter from consultant / GP / Health Professional			
Date of birth:	**/ /**		
Telephone No:			
Email Address:		**Postcode:**	

2. NAME OF PERSON COMPLETING THIS FORM ***if not the applicant***			
Full name:		**Address:**	
Relationship to applicant:			
Telephone No:			
Email Address:		**Postcode:**	
How did you find out about us?			

3. THERAPY GRANT APPLICATION		
You must complete all 3 questions in this section and send us all requested documents along with this application form.		***Tick to show you have completed / enclosed required paperwork***
3.1.	**Please tell us why you would like to apply for a grant towards a therapeutic service and how this will directly benefit the person being applied for;** (Please continue on a separate piece of paper if required)	
3.2.	**Please provide a detailed supporting letter from a health professional;** This needs to clearly detail how the requested therapy will benefit the applicant. ***Please advise us if this is not possible.***	
3.4.	**Please provide a detailed invoice from the therapeutic service.**	
HIPPOTHERAPY: If applying for a grant to fund hippotherapy, please note that we will fund 10 sessions at a time, and 2 blocks within a 12 month period.		

4. Have other charities and organisations been approached and what has been the response?	
1	
2	
3	

CONSENT & SIGNATURE	
By submitting your application you are consenting to your details being kept on our SCPS database.	
We would like to contact you regarding our future events. *Please tick here if you wish to be kept informed:*	
If you are interested in volunteering and would like us to contact you to discuss this please tick here:	

I confirm that the information on this form is correct. Name:

…………………………………………………………………………….

Signature:……………………………………………………………………….. Date:………../…………./…………….

PLEASE NOTE

We are unable to consider your application without all relevant or supporting documentation.
If any information is missing from your application this will delay your request.
If we need to write to you to request outstanding information but do not hear from you within 2 months from the date we contact you, we will close your request.
No monies will be paid to individuals *only suppliers of goods or services* by cheque or debit card only.
No monies will be paid retrospectively to any requests under any circumstances.

WHERE TO SEND YOUR APPLICATION & SUPPORTING DOCUMENTS;

BY POST: Shropshire Cerebral Palsy Society, PO Box 265, Oswestry, Shropshire, SY10 1FB
BY EMAIL: enquiries@shropshirecerebralpalsysociety.co.uk