STRICTLY PRIVATE AND CONFIDENTIAL

MOSMAN ANZAC MEMORIAL HALL TRUST

Website: **mamht.com**

CLAIM FORM: APPLICATION FOR WELFARE ASSISTANCE

NOTE: Fully and correctly completed Claim Form with appropriate documentation and receipts is to be sent as ONE DOCUMENT attached to an email to trustees@mamht.com

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OFFICE USE ONLY

Applicant Number: _____ Date application received: _____

PERSONAL DETAILS

Surname: …… Given Names: ……

Email and residential addresses: …… Postcode: ……

Telephone: ..... Date of Birth: ……..Certificate of Service/Mosman RSL Subbranch Number……

Bank Details: BSB……..Account Number: ……Account Name: ……

TYPE OF WELFARE ASSISTANCE REQUIRED

Complete appropriate section

A. Medical/Hospital/Dental/Optical/Pharmaceutical Expenses. (Include receipts)

Patient's Name	Relationship to applicant	Type of Service	Date of Service	Item No	Service Provided	Cost	Benefit	Gap	Receipt/Invoice attached as document number
			/ /						
			/ /						
			/ /						
			/ /						
			/ /						
			/ /						
			/ /						
			/ /						

Total: _____

(If there is insufficient space please use additional paper including all the above headings)

B. Domestic Support. (include receipts) _____

_____ **Amount: $_____**

C. Medical Appliances. (Include receipts) _____

_____ **Amount: $_____**

(Note: Medical appliances always remain the property of The Trust)

D. Utilities.(Include receipts)_____

_____ **Amount: $_____**

E. Aged/Home Care. (Include receipts) _____**Amount: $_____**

F. Mortuary. (Include receipts) _____ **Amount: $_____**

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. **Are you**: **a**. in a Private Health Fund? **Yes/No** **b**. a "returned serviceman/woman" or dependent of same or "war widow"? **Yes/No**

2. **Do you have a**: **a**. DVA Gold Card? **Yes/No** **b**. DVA White Card? **Yes/No.** **c**. Pensioner Concession Card? **Yes/No**

DECLARATION

I declare that I have incurred all the expenses for the above services and that the information provided is correct. I authorise the 'Trust' to contact DVA or the provider of any service claimed to obtain any information relating to the claim.

Total Claim Amount: $ _____

Signature of Applicant: _____**Date:**_____

Office Use only. Includes the verification of RSL membership or Evidence of Service & Approval for Payment

Approved/Not Approved: Trustee signature: _____ Name: _____ Date: _____

Approved/Not approved: Trustee signature: _____ Name: _____ Date: _____