

**Home Palliative / Frail / Disabled Care Assistance Policy**
*Care and support for old age illness, terminally ill, frail or disabled*

Provides each registered beneficiary, as well as their dependants and/or spouse, with financial assistance with the costs associated in caring for terminal, frail, aged or disabled persons, including cost of home care. Provides financial assistance to visit a person who is terminally ill, frail, aged or disabled.

**BENEFICIARY INFORMATION**

Application Date:	Date of Birth:	
Full Name:	Suffix: <input type="checkbox"/> Junior <input type="checkbox"/> Senior	
Street Address:		
City / Suburb:	State:	Postcode:
Email:	Phone:	

 Please tick if the phone number provided is a new number and you would like us to update your contact details

**APPLICATION DETAILS**

Patient Name:	Relationship of patient to beneficiary:
Assistance Required: <i>(Description of what care / assistance is required e.g. homecare, wheelchair etc)</i>	

**FUNDS REQUESTED**

Travel: \$ .....	<input type="checkbox"/> Fuel <input type="checkbox"/> Flights	Travelling from:
Diagnosis / Treatment: \$ .....	<input type="checkbox"/> Diagnosis / Tests <input type="checkbox"/> Surgery <input type="checkbox"/> Medication <input type="checkbox"/> Rehabilitation	
Appointment fees: \$ .....	Practitioner:	
Accommodation: \$ .....	Hotel / Provider:	
Other: \$ .....	Please specify:	
<b>TOTAL: \$ .....</b>	<b>Up to \$15,000 per beneficiary per financial year (included in overall combined limit of \$15,000)</b>	
Have you already paid the bill?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Supporting Documentation:**  Supporting documentation from relevant Medical Professional / appointment confirmation  
 Invoice / quote / receipt detailing services and outstanding amount is attached or paid.  
 Supplier contact, payment details and ABN, these details should be included on the supplier invoice.

**Applications will NOT be processed until supporting documentation and supplier payment details are received.**

- I am not eligible for benefits from any other funding source for these expenses (e.g. another Trust, insurance company or government agency).
- I understand that my application will be processed by the Trustee (Mutual Trust) within **FIVE (5) business days once all required supporting documentation has been received.**

**Beneficiary Signature:** ..... **Date:** / /

**NOTE: Please keep a record of your receipts as you may be asked to account for how these funds were spent as per the Yinhawangka Charitable Trust Deed.**

**Please send completed forms and supporting documents to Mutual Trust by:**

**Fax:** (08) 9230 7701 **Email:** [perthadmin@mutualtrust.com.au](mailto:perthadmin@mutualtrust.com.au) **Mail:** Mutual Trust, PO Box 122, NEDLANDS WA 6909  
 If you have any queries, please contact us on (08) 9230 7700