****

**Food Voucher Application**

This Food e-Voucher request form is to help CF patients and families who are experiencing real difficulty. To qualify they should be receiving benefits, on low income or unemployed. If you have any queries or difficulty completing this form, please call us on 01677 470469.

Our Support Service tries to ensure applications for grants are dealt with promptly and sensitively. We ask for detailed information in order to speed up your request. Please complete the supporting information below as to why your patient is in need.

Please ensure a paediatric patient’s parents are aware you will be passing on their contact details to CF Care to enable us to organise the appropriate voucher. All personal details are kept private, confidential and are never shared.

**All parts of this form must be completed by a CF Team member or social worker.**

**Please complete ALL BOXES and return by email to** [**contactus@cysticfibrosiscare.org.uk**](mailto:contactus@cysticfibrosiscare.org.uk)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Food Voucher Grant**  **(£100 for an individual)** |  | **Food Voucher Grant**  **(£200 for a family)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full name of person with CF** |  | | | | |
| **Patient Date of Birth** |  | | | | |
| **Parent Name (If patient is under 16)** |  | | | | |
| **Address** |  | | | | |
| **Number of dependants** |  | | | | |
| **How many people in your family have CF?** |  | | | | |
| **Patient/Parent Contact Phone Number** |  | | | | |
| **Patient/Parent Email Address** |  | | | | |
| **Which Supermarket do you wish to use?**  **We only provide vouchers for Tesco, ASDA, Morrison’s, Sainsbury’s and Aldi.** | **Tesco** | **ASDA** | **Morrison’s** | **Sainsbury’s** | **Aldi** |

**All our grants must be signed off by a member of the CF team making the request on behalf of their patient. Please complete this part of the form.**

|  |  |
| --- | --- |
| **CF Consultant Name** |  |
| **CF Consultant Email Address** |  |
| **CF Consultant Signature & Date** |  |

|  |  |
| --- | --- |
| **CF Team member’s name** |  |
| **Hospital Address** |  |
| **Telephone number** |  |
| **Email** |  |
| **CF Team Signature**  **Date** |  |

|  |  |
| --- | --- |
| **SUPPORTING INFORMATION – FINANCIAL** | |
| **Are you or your partner in work?** |  |
| **What is your household income and benefits combined?** |  |
| **Do you live in rented property or own your own home?** |  |

|  |  |
| --- | --- |
| **SUPPORTING INFORMATION** – **Giving reasons why the grant is required** **to include the health of the patient, specific problems, is there a change in circumstances?**. | |
|  | |
| **Signature** |  |
| **Date** |  |

**Data Protection Statement**

Your personal information (data) collected on this form, and on the attachments, (which includes the collection of sensitive personal data) are collected for the purposes of providing a grant. It is the policy of CF Care to protect, and keep secure, all personal data collected. All personal data is processed for the purposes, in the case of successful applicants.

**Further Help:**

Further support is available from foodbanks. If the patient would like a referral, please email [contactus@cysticfibrosiscare.org.uk](mailto:contactus@cysticfibrosiscare.org.uk) They can also search www.trusselltrust.org/get-help/find-a-foodbank/