

48b High Street

Cosham

Portsmouth

Hampshire

PO6 3AG

Tel: 02392 612334

Information

**Who can apply for a FFC Grant?**

* People who have cancer and are on a low income with little savings.
* Grants are given to patients of all ages
* Grants will also be given to people who previously had cancer and are now suffering from cancer related disabilities.

**How much can FFC give?**

FFC have limited funds available and the majority of grants are small.

All applications are considered and FFC will help where they can.

Grants are limited to **1 per person,** this will ensure that we help as many people as we can.

**Financial Information**

*All Applications are means tested, this ensures that grants are given to people who require them the most.*

To be eligible for a FFC Grant you must fall within the criteria below

* Live in the area that is served by the Portsmouth Hospital NHS Trust
* Have lived in the area for over 5 years. If now living outside this area evidence is required such as supporting letter or evidence of a utility bill/council tax.
* Have savings under £6000 if single, or £8000 as a couple or family
* Your household disposable income per week after Mortgage, Rent & Council Tax, is under:
* £170 for a single person
* £289 per couple
* £85 per child (Family)
* £119 for each additional adult working (only when their income is relevant to the request

**EVIDENCE OF INCOME IS REQUIRED BY WAGE SLIP OR BY ALL BANK STATEMENTS.**

**How are grants sent out?**

If you are successful with your application, grants will be sent directly to the patient in the form of a cheque.

If the grant is for a person aged under 18 the cheque will be made payable to the parent or guardian.



Football For Cancer

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FFC GRANT APPLICATION FORM

THE INFORMATION YOU SUPPLY ON THIS FORM WILL BE TREATED IN CONFIDENCE

By completing and applying for a FFC Grant, you give permission for us to use your non-identifiable data (no names/addresses)

Please complete this form fully using pen ink or type

If you have any questions please email [grants@ffcevents.com](mailto:grants@ffcevents.com) or call 02392 612334

Personal Details

First Name:

Surname:

Title:

Surname:

rname:

:

Surname:

Surname:

Mobile

Home

Female

Male

Surname:

DOB

Address:

Postcode

**Surname**:

Gender

Contact

Signature of applicant or parent

Date

Surname:

*This section must be completed by a Macmillan nurse, GP, hospital doctor or a Clinical Nurse Specialist –* ***DS1500 is not accepted***

Medical Information

Date of Diagnosis

Diagnosis

Surname:

Prognosis if known

Surname:

If yes, what treatment is being given?

Surname:

No

Surname:

Yes

Is treatment being received?

Supporting statement for application.

Please include as much as you can to explain the situation.   
  
Please continue on a separate sheet if necessary

Surname:

Surname:

Signed

Surname:

Official Capacity

Name of Medical Signatory

Department Stamp

Surname:

Date

**Please enclose a recent bank statement and relevant wage slips**

Financial Information

|  |  |  |
| --- | --- | --- |
|  | Weekly | Monthly |
| Current Wages (after deductions) | **£** | **£** |
| State Pension | **£** | **£** |
| Pension Credit | **£** | **£** |
| Other Pensions | **£** | **£** |
| Statutory Sick Pay | **£** | **£** |
| Child Benefit | **£** | **£** |
| Employment & Support Allowance | **£** | **£** |
| Universal Credit | **£** | **£** |
| Income Support | **£** | **£** |
| Tax Credits (Work/Child or Both) | **£** | **£** |
| Any Other Income | **£** | **£** |

*We do not take the following benefits into account when dealing with your grant application, but they must be stated*

|  |  |  |
| --- | --- | --- |
|  | Weekly | Monthly |
| Attendance Allowance | **£** | **£** |
| Disability Living Allowance | **£** | **£** |
| Personal Independent Allowance | **£** | **£** |
| Housing Benefit | **£** | **£** |

**Outgoings**

|  |  |  |
| --- | --- | --- |
|  | Weekly | Monthly |
| Mortgage | **£** | **£** |
| Rent (after Housing Benefit) | **£** | **£** |
| Council Tax | **£** | **£** |

**Details of all other household members**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Weekly Income | Monthly Income | Relationship to patient |
|  |  | **£** | **£** |  |
|  |  | **£** | **£** |  |
|  |  | **£** | **£** |  |
|  |  | **£** | **£** |  |

**Occupation**

|  |  |
| --- | --- |
| Patient |  |
| Partner (if applicable) |  |

Grant Request Information

|  |  |
| --- | --- |
| Please specify the items/purpose you are applying for | Amount |
|  |  |
|  |  |
|  |  |
|  |  |

*Please note that it may not be possible to assist with all items*