

CYSTIC FIBROSIS ASSOCIATION OF NEW ZEALAND

HOSPITAL ALLOWANCE CLAIM FORM

Applicant's name: Phone:.....

Residential Address:

Postal Address (if different from above):

..... Mobile:

Email Address: Today's Date:

Bank Account #: Bank and Branch:

(Giving us your bank account details allows us to deposit your grant directly into your account, which is the fastest method of reimbursement.)

Patient's Name:..... Date of Birth:

Period in Hospital: In Out Hospital:

Signature of Applicant:

When you are on transfer from your base hospital, or when admitted to a hospital more than 100 kilometres from your current residence, you are entitled to an allowance of \$20 per night of your stay, as a contribution towards extra costs incurred or lost income. When filling in this form please make sure you attach either your discharge papers showing the dates of your stay in hospital, or a signed verification of the dates above from the CF specialist nurse or the nurse in charge of the ward.

Please return the form with discharge papers or signed verification below to: Administration & Support Manager, CF Association, Box 8241, Christchurch. If you have any questions, please phone the Association on 0800 65 1122.

*Your claim will be dealt with as quickly as we are able, and the grant deposited directly into your bank account if the details are provided above. **PLEASE NOTE: We accept no responsibility for payments going astray, if you provide an incorrect bank account #.** Alternatively, if you prefer, a cheque made out to the applicant's name will be sent to the postal address above unless you request otherwise. The amount of the grant may be adjusted to take into account any payment that may have been made to you in advance.*

Verification of hospital stay (if required because discharge papers are not available):

.....
.....
.....

Name: Position Held:

Signature: