

**Hospital Allowance**

**Application Form**

When you are on transfer from your base hospital, or when admitted to a hospital more than 100 km from your current residence, you’re entitled to an allowance of $20/night of your stay. This is a contribution toward the extra costs incurred or for lost income.

**When filing this form please attach your discharge papers or have it signed by your CF fieldworker, CF specialist nurse or charge nurse of the ward.**

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| --- | --- | --- |
| **PWCF details:** |  |  |
| Name: |  | Birth date: |  |
| Address: |  |  |  |
|  |  | Email: |  |
| City: |  | Phone: |  |
| Postcode: |  | CF Branch: |  |
|  |  |  |  |
| **Applicant:** |  | Relationship: |  |
| Address: |  |  |  |
| (If different from above) |  | Email: |  |
|  | Phone: |  |
|  |  |  |  |
| **Details of Application** | Application date: |  |
| Hospital check-in date: |  | Discharge date: |  |
| Hospital: |  |
| Signature of applicant: |  |
|  |  |  | Have you attached a copy of the discharge papers? If not available, please have your hospital stay verified by the CF specialist nurse, your fieldworker or the charge nurse of the ward. |
|  |  |  |
|  |  |  |
| **Verification:** |  |  |
| Name: |  | Position held: |  |
| Signature: |  |
|  |  |
| **Details of Payment:** |  |  |
| Payment Method: |  | Direct Deposit | Account No: | \_ \_ - \_ \_ \_ \_ - \_ \_ \_ \_ \_ \_ \_ - \_ \_ \_ |
|  |  |  |  |  |
| Your claim will be dealt with as quickly as possible and the grant can be deposited directly into your bank account. **Receipt/s as well as proof of bank account name and number must be submitted along with this form** **(eg bank statement, screenshot of name and account number).** **Please note:** we accept no responsibility for payments going astray if you provide incorrect bank details. A maximum of 14 days stay in hospital will be paid. Please either email this form to admin@cfnz.org.nz or mail (with discharge papers or verification) to; **Office Manager, CFNZ, PO Box 110 067, Auckland Hospital, Auckland 1148.** |