



Muscular Dystrophy  
New Zealand

APPLICATION FORM

MDA Member's Discretionary Fund

**Note:** You must be a registered member and have a neuromuscular condition that is covered by the MDA to apply to this fund.

<b>Applicant Name:</b>		<b>Membership Number:</b>	
<b>Email:</b>		<b>Phone: Mobile:</b>	
<b>Address:</b>		<b>Preferred Contact Method:</b>	<input type="checkbox"/> Phone <input type="checkbox"/> Mobile <input type="checkbox"/> Post <input type="checkbox"/> Email
<b>Condition:</b>		<b>Date of Birth:</b>	

1. Please describe the resource/equipment/activity you are seeking funding for?
2. How will this resource/equipment/activity enhance your life?



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3. Does this resource/equipment/activity meet criteria for government funding?  
Yes / No

(Please provide evidence where possible, e.g. copy of decline letter or eligibility criteria for Ministry of Health.)

4. Amount you are applying for: \$\_\_\_\_\_

Are you applying to MDA for full (total cost) or partial funding? Full / Partial

If you are applying for partial funding, how will you make up the difference required?

5. Have you successfully applied to the discretionary fund before? Yes/ No  
If Yes when?

**I declare that all information contained in this application is true and correct.**

**I consent to MDA contacting a supplier to verify costs and/or any person who is identified on supporting evidence, in relation to this application.**

**Signature:**

**Name & Relationship to Applicant: (if applying on behalf of someone else)**

**Date:**

MDA Member's Discretionary Fund Application Form	Date Implemented: Jan 2016	Last review date: Mar 2017
Page 2 of 3	Authorised by: Chief Executive	Next review date: Mar 2018



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### Supplier Information:

<b>Company:</b>			
<b>Contact Person:</b>		<b>Role:</b>	
<b>Phone Number(s):</b> <b>Email:</b>			
<b>Reference: (e.g. Quote or Invoice number)</b>			

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### Additional Notes: (Optional information that may assist the MDA with your application)

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