

## **BENEFICIARY APPLICATION**

#### PLEASE READ THE GUIDANCE NOTES BELOW BEFORE COMPLETING THE APPLICATION

#### **Section 1: Referrer Details**

Completed by the Referrer (Could be FAMILY DIRECTLY / SOCIAL WORKER / HOSPITAL / HOSPICE OR OTHER CARE SETTING)

# Section 2: Family / Carer Contact Details

#### **Section 3: Patient Details**

### **Section 4: Application Details**

# **Section 5: Declaration and Verification of Application**

# Section 6: Consent to process personal data

Completed by the applicant's parent or guardian, or by the young person if over 16 and able to do so

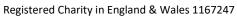
- Applications will be accepted from:
  - Directly from the family or young person if over the age of 16.
  - The young person's social worker
  - Marie Curie Nurse / Macmillan Nurse
  - POONS team
  - Hospital Consultant or other relevant clinician (including Clinical Nurse Specialists)
  - GP or other senior health professional involved in the young person's care
- The young person must be aged under 25 (0 24 years + 364 days)
- All applications must be verified and signed by the referrer (Section 5) in the knowledge that the application is being made on behalf of the patient.
- Please be aware that each application is assessed by the Board of Trustees and it is not guaranteed that every application will be successful. You are therefore advised not to promise/guarantee the young person or their family that the application will be successful.
- The application must be made within a reasonable timeframe to enable DCT to respond appropriately and allow the recipient to use the gift in the way in which it was applied for.
- Please be aware that by making this application you are required to provide confirmation that the medical team consider that the young person's cancer to be life threatening.

### **How to Submit:**

- Via Mimecast
- Password protected (encrypted) email to info@dragonflycancertrust.org

Please do not attach this application to an email

#### **LATEST VERSION 2.4 20/02/2024**





#### **SECTION 1 - REFERRER DETAILS**

TO BE COMPLETED BY THE REFERRER (FAMILY DIRECTLY / SOCIAL WORKER / HOSPITAL / HOSPICE OR OTHER CARE SETTING)

Submission Date	
Hospital Name	
Referral made by (name)	
Job title	
Working days	
Telephone	
Mobile number	
Email	
Working days Telephone Mobile number	

We require this information to so that we can contact you should our Trustees have any questions in relation to the application.

## SECTION 2 – ESSENTIAL FAMILY / CARER CONTACT DETAILS.

TO SPEED UP YOUR APPLICATION IT IS ESSENTIAL THAT ALL SECTIONS ARE COMPLETED IN FULL

Patients name		
Principle carer name(s)		
Relationship to applicant		
Details of siblings including ages		
Address		
Home telephone		
Mobile		
Email		
Bank account information	Name on account	Sort code
(For intended Cash Gift recipient)	Name of bank	Account number

This information is required to enable DCT to establish how the gift will be facilitated and to discuss any additional requirements/requests which need to be considered to process the application. This includes sibling or memory boxes and other services we provide.

### **LATEST VERSION 2.4 20/02/2024**



Full name of patient

Registered Charity in England & Wales 1167247

### **SECTION 3 - PATIENT DETAILS**

Age on date of application		Date of birth	
Diagnosis			
SECTION 4 - APPLICATION	ON DETAILS		
What is the application for – I contact the office on info@dr		ere patients require	more than one of the following please
☐ Cash Gift	☐ Parkdean St	ay	☐ Memory Box
☐ Center Parcs break	☐ Personalised	d Glass Heart	☐ Sibling Box
What impact will this support	t have on the young perso	n and their family? <i>I</i>	Please select any / all that apply.
☐ Create memories	☐ Reduce stress	i	☐ Assist with the journey of grief
☐ Provide a focus	☐ Connect the f	amily	☐ Fulfil a final wish
☐ Take away the pressure oneeding to arrange something		•	☐ Dignity – not needing to ask others for money
special  Peace of mind	☐ Impact on the able to fulfil their	e patient of being wish(es)	☐ Help the family come to terms with the circumstances
☐ Create a platform for discraround cancer	ussion		☐ Reduce anxiety on the family as a whole
☐ Other Please specify where possible	2:		
Is the family in the process of jeopardise the application.	applying for other wishes	/support, please hig	hlight below. This information will not
☐ Yes – Please give further de	etails: $\square$ N	0	
IMPORTANT - Are there any of the applicant and/or benefic			e aware of before making contact with

We require the above information to demonstrate the applicant sits within the application criteria and to ensure the work carried out by the DCT team does not conflict with any other organisation appealing for a similar wish for the same applicant. We may also be able to facilitate a wish that exceeds the Cash Gift value.



#### **SECTION 5 – DECLARATION AND VERIFICATION OF APPLICATION**

to time to ensure appropriate authorisation has been granted.

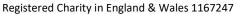
TO BE COMPLETED BY THE REFERRER

#### **DECLARATION**

I confirm that at the time of application, the patient named above is suffering from a life-threatening cancer diagnosis and the request meets the criteria set out in the guidance notes and is for the purposes stated in the application.

Referrer name		
Signed Electronic or typed signature accepted to avoid referral delays*		
Date		
Source of support confirmation (Please tick)	_	ficiary / the beneficiary's family have been made d in this application is being obtained from
Patient's	☐ Aware/Cognisant	☐ Unaware at this stage
understanding of their condition	☐ Too young/poorly to process	☐ Other (please provide details)
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#### LATEST VERSION 2.4 20/02/2024





#### **Privacy Statement**

Dragonfly Cancer Trust will not use or share this information other than to satisfy the application criteria. All applications will be destroyed within 12 months of submission.

For further details please see our Privacy Policy which can be viewed at: <a href="https://www.dragonflycancertrust.org/privacy-policy">www.dragonflycancertrust.org/privacy-policy</a>

Should you have any questions in relation to this application you may contact the office by email <a href="mailto:info@dragonflycancertrust.org">info@dragonflycancertrust.org</a> or by telephone on 0191 2610971 / M; 07491641668.

#### **Further Guidance Notes, Terms & Conditions**

- 1. The Trustees will consider applications to support children and young people with a life-threatening cancer diagnosis to achieve their wishes with a clear focus on memory making. The application should clearly demonstrate the impact that the gift will have on the applicant and his/her family.
- **2.** It would be extremely helpful if you can make DCT aware of any special/difficult circumstances the team should be aware of before contacting the family.
- 3. Grant outcomes are carefully considered and deemed final without recourse to appeal or challenge.
- **4**. The Cash Gift is awarded to the recipient in good faith for the purpose for which it was applied for and cannot be reissued to family members should circumstances change. Whoever is making the application should be mindful of any time constraints when applying for support.
- **5**. Please send a separate email to <a href="mailto:info@dragonflycancertrust.org">info@dragonflycancertrust.org</a> confirming that you have submitted a form if via Mimecast.

If you have any questions, or if you have not heard from DCT within **7** days of submitting the application, please contact the office:

Telephone: 0191 2610971 / Email: info@dragonflycancertrust.org Dragonfly Cancer Trust, Registered Charity 1167247

In line with the recent GDPR, we have reviewed how we receive and process our applications and we would be most grateful if you would follow the guidelines for submission outlined in the covering e mail and on our website.