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| **The Gyde Charity****Grant Application Form**Registered Charity No. 311529 |   |

**Please complete all sections below. If necessary, write ‘0’ or ‘not applicable’. If there is insufficient space on the form, please provide additional pages.**

To be considered for a grant from the Charity, the person who will benefit must be under the age of 25 and are either in need, hardship or distress or have speech, hearing or sight impairment.

Return the completed form by email to: info@thegydecharity.org or by post to:

Mrs. S. Baker

Clerk to The Gyde Charity

14 Green Close

Uley

Dursley

GL11 5TH

***Who would benefit from a grant?***

|  |
| --- |
| Full name |
| Address |
| Postcode |
| Date of birth |
| Total monthly income (including job and/or benefit income) if aged over 18  £\_\_\_\_\_\_\_\_\_\_ |
| If total monthly income exceeds £1,500 please explain financial situation |

***Parents or Guardians details***

|  |  |  |
| --- | --- | --- |
|  | *Responsible Adult 1* | *Responsible Adult 2* |
| Full name |  |  |
| Address (if different from beneficiary) |  |  |
| Postcode |  |  |
| Occupation |  |  |
| Telephone number |  |  |
| Email address |  |  |
| Number of people living in household |  |
| Total monthly household income (including job and/or benefit income) | £\_\_\_\_\_\_\_\_\_\_\_ |
| If monthly household income exceeds £2,500 please explain financial situation |  |

***Details of grant requested***

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| --- |
| Purpose |
| Please explain the reasons for the application and the equipment or therapy needed (attach quotations received): |
| Total cost | Amount from Gyde Charity | Amount from other sources |
| £\_\_\_\_\_\_\_\_\_\_\_\_\_ | £\_\_\_\_\_\_\_\_\_\_\_\_\_ | £\_\_\_\_\_\_\_\_\_\_\_\_ |
| If successful who should the cheque be made payable to? |

***Medical condition***

|  |
| --- |
| If the beneficiary has speech, hearing or sight impairment please explain their medical condition |
|  |

***Signature***

|  |
| --- |
| I confirm that the information in this application is correct |
| Signature |
| Print name |
| Date |

***Professional endorsement: (Doctor, Social Worker, Teacher or Similar***)

|  |
| --- |
| Please confirm the beneficiary’s medical condition and explain the benefits of the proposed equipment or therapy: |
| Signature |
| Print name |
| Job title |
| Date |
| Telephone number |
| Email address |