

**South West Boojarah Charitable Trust**  
**APPLICATION FOR DISABILITY ASSISTANCE**

**GUIDELINES FOR PAYMENTS OF DISABILITY ASSISTANCE**

1. Applicants must be **South West Boojarah Native Title Claimants** (as per the Deed);
2. Applicants are **suffering some form of medical condition or disability** where they need equipment to improve the quality of their lives;
3. Applicants have a **Medical professional letter/certificate** indicating that such equipment is needed to improve the quality of their life due to this medical condition;
  - a. **Assistance up to \$2,000 per person** is available as a contribution to the purchase medical or mobility equipment, including but not limited to:
    - i. Mobility equipment
      1. Wheelchairs
      2. Gophers
      3. Walking frames
    - ii. Other medical equipment
      1. Sleep Apnoea respiratory machines
  - b. **Assistance up to \$250 per person for Prescription Glasses**
4. **Medications will not be funded** (as they are recurrent expenses)
5. **Funding will be provided to the supplier** of equipment – no payments to individuals;
6. Applicants are to apply to the Advisory Committee/Trustee, with at least **two quotes from providers** for the purchase of items under 3(a).
7. Once funds for a financial year have been exhausted, no further applications will be considered.
8. Where the equipment is more than \$2,000, the **applicants must indicate have the excess funds** available to make up the difference.
9. Note the more **information provided** in the Application – the quicker the application will be processed.

**APPLICANTS DETAILS**

**APPLICANT NAME:** \_\_\_\_\_

**APPLICANT ADDRESS:** \_\_\_\_\_

**APPLICANT TELEPHONE NO:** \_\_\_\_\_

**ARE YOU A MEMBER OF THE SOUTH WEST BOOJARAH CLAIMANT GROUP?** YES NO

**DETAILS OF FAMILY MEMBER (IF APPLYING ON APPLICANT'S BEHALF)**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

**APPLICANTS CONSENT TO RELEASE INFORMATION**

I \_\_\_\_\_ give permission for the South West Aboriginal Land and Sea Council (SWALSC) researchers to confirm my connection to the South West Boojarah language group, and release family connection advice to the Trustee of the SWB Charitable Trust, Equity Trustees.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DETAILS OF APPLICANT'S FAMILY CONNECTION TO SWB CLAIMANT GROUP**

MOTHER'S SIDE	SURNAME	GIVEN NAME	FATHER'S SIDE	SURNAME	GIVEN NAME
MAIDEN NAME: →			NAME: →		
GRANDMOTHER'S MAIDEN NAME: →			GRANDMOTHER'S MAIDEN NAME: →		
GRANDFATHER'S NAME: →			GRANDFATHER'S NAME: →		

**Note – The section above MUST be completed for consideration.**

**Please contact SWALSC researchers if you require help identifying family connections.**

**DETAILS OF MEDICAL CONDITION**

MEDICAL CONDITION: \_\_\_\_\_

MEDICAL EQUIPMENT REQUIRED: \_\_\_\_\_

AMOUNT OF ASSISTANCE REQUESTED: \_\_\_\_\_

**SUPPORTING MATERIAL**

**DOCTOR'S DETAILS: (Please attach a letter from your Doctor or Occupational Therapist confirming your medical condition and your need for this equipment)**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

INVOICE NO: \_\_\_\_\_

**South West Boojarah Charitable Trust**  
**APPLICATION FOR DISABILITY ASSISTANCE**

**SUPPLIER'S DETAILS: (Please attach at least two quotes for the equipment to this application)**

**SUMMARY OF QUOTES:**

SUPPLIER:	ITEM:	COST:

**DECLARATION BY THE APPLICANT**

I declare that all the information provided with this application is true and correct to the best of my knowledge. I acknowledge that any recommendation made to the Trustee in relation to this application is at the complete discretion of the South West Boojarah Charitable Trust Advisory Committee, and in the event assistance is provided and it transpires that I have knowingly provided false or misleading information, that this application will be rejected and that I may be requested to repay any monies expended from the Trust as a result of that false and misleading information.

**APPLICANT'S SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PLEASE FORWARD YOUR COMPLETED APPLICATION TO:**

**Email (fastest way):** [communitytrusts@eqt.com.au](mailto:communitytrusts@eqt.com.au)

**Post:** Equity Trustees, Level 12, 197 St Georges Terrace, Perth WA 6000

**Fax – (03) 8623 5200**

**Enquiries – 1300 133 472**