



GUMALA ABORIGINAL CORPORATION

HEALTH ASSISTANCE PROGRAM

APPLICATION FORM 1.1



Members Name: _____

Address: _____

DOB: ____ / ____ / ____

PHONE: _____

EMAIL: _____

Language Group: Banyjima

Innawonga

Niyaparli

Please note items for Health Assistance must be **\$50 or more** in value in order for an application to be processed. Gumala provides funding for a number of items under this program. Which category best describes does your request?

- Payment towards health insurance policy
- GP or Specialist Doctor Bill
- Dentist, Optician, Chiropractor, Physio Therapist
- Specialist Medical Equipment

- Pharmacy items as prescribed by a doctor only
- Rehabilitation Costs
- Dietitian Fees or Meal Programs
- Other: _____

Details of Request:

Items:	Inv./Quote No.:	Supplier:	Phone:	Amount:
Total:				\$

Comments:

Check List (Please Tick):

	Application form is signed and dated
	Quote / Invoice is attached
	I understand GAC does not pay for treatment plans
	If request is for a child, I have ensured that the child is a registered Beneficiary with GAC

Please Note: Once all documentation has been received your application will be processed within 7 business days.

I consent to GAC sharing my personal details and information with other organisations, where reasonably necessary, to assist with the provision, management and monitoring of goods or services.

Signature: _____

Date: _____

HEAD OFFICE - 1 Stadium Road, Tom Price, WA 6751

POSTAL ADDRESS - PO Box 3167, East Perth, WA 6892

PHONE - 1800 486 252 (1800 GUMALA) EMAIL - applications@gumala.com.au FAX - 08 9188 1846

Disclaimer: Application approvals are subject to eligibility and program guidelines criteria. The Trustee only provides funding for Members and Beneficiaries that are on its register.