GUMALA ABORIGINAL CORPORATION

HEALTH ASSISTANCE PROGRAM

APPLICATION FORM 1.1

Members Name: _____

Address: _____

DOB: _____ / _____ / _____ **PHONE:** _____ **EMAIL:** _____

Language Group: ☐ **Banyjima** ☐ **Innawonga** ☐ **Nyiyaparli**

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 9219 4555