

# PUKEROA ORUAWHATA CHARITABLE TRUST

(REGISTERED AS A CHARITABLE ENTITY UNDER THE CHARITIES ACT 2005 – NO.CC 54811)

## HEALTH GRANT APPLICATION

Name of Applicant:	_____	_____
	First Name/s	Surname
Address:	_____	
		Post Code:
Home phone:	Mobile:	E-mail:
Date of Birth:	<i>(attach evidence of age)</i>	
Personal Photo ID	<i>(attach driver's license or passport)</i>	

### HOW ARE YOU ELIGIBLE TO APPLY? *(please circle)*

Shareholder in Pukeroa Oruawhata Trust	Descendant of shareholder	Whānau Trust beneficiary	Whakapapa to one of the 6 Ngāti Whakaue koromatua
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### PUKEROA ORUAWHATA TRUST SHAREHOLDER or DESCENDANT OF SHAREHOLDER DETAILS:

Name of Shareholder: <i>(the owner of the shares)</i>	_____	_____
	First Name/s	Surname
Birth Certificate:	<i>(attach copy of birth certificate/s or provide whakapapa showing your relationship to the shareholder)</i>	

### PUKEROA ORUAWHATA TRUST WHANAU TRUST SHAREHOLDER DETAILS:

**(Complete this section only if you are a beneficiary of a Whanau Trust – your application must be signed by two current trustees of your Whānau Trust. Trustees who sign verify that the applicant holds whakapapa to one of the 6 koromatua of Ngāti Whakaue).**

Name of Whanau Trust:	_____	
Trustee of Whanau Trust:	_____	_____
	Name of Trustee of Whanau Trust	Trustee Signature
Trustee of Whanau Trust:	_____	_____
	Name of Trustee of Whanau Trust	Trustee Signature

### PLEASE PROVIDE YOUR FULL WHAKAPAPA TO ONE OF THE 6 KOROMATUA OF NGĀTI WHAKAUE

**LISTED BELOW ON A SEPARATE PAGE:** *(Only if you are not eligible as a shareholder, descendant of shareholder or Whanau Trust beneficiary)*

Hurunga te Rangi / Pūkākī / Rangi I Waho / Taetou / Te Roro o te Rangi / Tūnohopū

PURPOSE AND DOCUMENTATION: <i>(please circle)</i>			
EYE HEALTH (up to \$400 max)	ORAL HEALTH (up to \$400 max)	HEARING HEALTH (up to \$400 max)	OTHER (at the Trustees' discretion)
FINANCIAL DETAILS:			
Payment to:	PLEASE SELECT: Reimburse me <input type="checkbox"/> <b>or</b> Pay Supplier <input type="checkbox"/>		
Bank Account No:	Required only if you are seeking reimbursement. <u>(attach evidence of bank account number or deposit form)</u>		
Other organizations applied to for assistance with these costs:			
Quote:	<u>(attach quote)</u>		
Receipt/s:	<u>(attach receipts if payment already made)</u>		
Will the treatment/service be undertaken in New Zealand?		YES	NO
I DECLARE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:			
Signed by Applicant:		Dated:	

**IMPORTANT: Please read the Policy and complete CHECKLIST below**

**Health Grant Policy and Criteria:**

1. Reimbursement to the applicant must be supported by a receipt **itemising treatment or purchase**.
2. For applicants seeking reimbursement for costs paid via WINZ, the grant will only cover the WINZ loan. Please attach the WINZ **repayment schedule**.
3. Approved quote applications - the supplier will invoice Pukeroa on completion of treatment which must be completed within 12 months.
4. Treatment must be undertaken in NZ and payment made to a NZ bank account.
5. **One** Health grant for **either** eye, oral, ear or other health only – **not** a combination thereof and is limited to one Health Grant in any 12 month period.
6. For 'OTHER' health related costs, approval will be granted at the Trustees discretion.
7. The applicant must disclose any other funding received or applied for from other organizations for the same quote or invoice.
8. In signing the application, the applicant acknowledges that information provided may be shared with Ngāti Whakaue Tribal Lands Incorporation and that the service provider may be contacted to confirm any aspect of the application.
9. The processing of applications is subject to the completeness of the information provided.
10. Grants are at the absolute discretion of the Trustees and no correspondence will be entered into once the decision has been made.
11. There will be no urgent requests.
12. Any increase/decrease in grant limits will not be backdated. POCT reserves the right to amend grant values from time to time.

Checklist  - **Remember – you MUST complete and attach to this application the following or your application will not be processed.**

- All applicable sections are completed.
- Copy of **Personal Photo ID** which includes your date of birth (*e.g. driver's license, passport*).
- Your own **Bank account deposit slip** or **evidence of bank account number** – (*reimbursement applicants only*).
- Receipt **or** Quote **and** itemised treatment/purchase
- Birth Certificate (*if applicable*).
- WINZ repayment schedule (*if applicable*).

**Please forward your application to:**

Pukeroa Oruawhata Charitable Trust. PO Box 12031 · ROTORUA 3045 · Level 1 · Pukeroa Oruawhata House · 1176 Amohau Street · ROTORUA. Email: [grants@pukeroa.co.nz](mailto:grants@pukeroa.co.nz) 07 9299806

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