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:
Personal ID:	*(attach driver's license, passport or Birth Certificate)*	

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

PUKEROA ORUAWHATA TRUST SHAREHOLDER or DESCENDANT OF SHAREHOLDER DETAILS:

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

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

Whanau Trust Name:		
Trustees of Whanau Trust:	Name of Trustee of Whanau Trust	Trustee Signature
	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 / Taeotu / Te Roro o te Rangi / Tūnohopū

PURPOSE: ***(please circle)***

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 ☐	***or*** Pay Supplier ☐
Bank Account No:	Required only if you are seeking reimbursement.	(attach evidence of bank account number or deposit form)

Other organizations applied to for assistance with these costs, including WINZ:		
NOTE: If application has been made to WINZ for Dental support it must be disclosed. By applying for dental cost assistance I confirm and acknowledge Pukeroa Oruawhata Charitable Trust will contact the supplier to ascertain whether WINZ will support any aspect of my dental treatment. I confirm Pukeroa Oruawhata Charitable Trust reserves the right to hold applications until such time as the application is complete in every aspect.		
Declaration:	I have NOT applied to WINZ ☐	I have applied to WINZ and been declined ☐
Quote:		(attach quote)
Receipt/s:		(attach receipts if payment already made)
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** (and not be older than 12 months from month of application.)
2. **WINZ ORAL/DENTAL** grants. If application has been made to WINZ for Dental support it must be disclosed.
3. The supplier will be contacted to verify **all Dental** applications and their method of payment.
4. For applicants seeking reimbursement for costs paid via **WINZ**, the grant will only cover the WINZ loan. Please attach the WINZ **repayment schedule.**
5. The applicant must disclose any other funding received or applied for from other organizations for the same quote or invoice.
6. Approved quote applications - the supplier will invoice Pukeroa on completion of treatment which must be completed within 12 months.
7. Treatment must be undertaken in NZ and payment made to a NZ bank account.
8. **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. Multiyear grants will not be provided for **same treatment**, regardless of cost of treatment or payment plan.
9. For 'OTHER' health related costs, approval will be granted at the Trustees discretion.
10. The processing of applications is subject to the completeness of the information provided.
11. Grants are at the absolute discretion of the Trustees and no correspondence will be entered into once the decision has been made.
12. There will be no urgent requests.
13. Any increase/decrease in grant limits will not be backdated. POCT reserves the right to amend grant values from time to time.
14. 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.
15. Confirmation of whakapapa from Te Komiti Nui or Ngāti Whakaue Koeke/Kaumatua may be required to validate your application.

Checklist ☑ **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 Identification,** preferably which includes your date of birth and photo identification.
- ☐ **Bank account deposit slip** or **evidence of bank account number** – (*reimbursement applicants only*).
- ☐ Receipt ***or*** Quote ***and*** itemised treatment/purchase
- ☐ WINZ repayment schedule (*if applicable*). WINZ Dental Scheme – declined letter or evidence your WINZ application was not successful, for dental treatment under the 'immediate & essential dental work' scheme announced by Govt, 01 December 2022.