HAVELOCK NORTH WATER CONTAMINATION
COMMUNITY HEALTH ASSISTANCE APPLICATION FORM

APPLICATION FOR ASSISTANCE WITH THE EFFECTS FROM LONG-TERM ILLNESS

The assistance is for people who have suffered symptoms consistent with campylobacter (caused by the Havelock North water event of August 2016) and who have continued to suffer a recognised long-term illness linked to those symptoms. Long-term is defined as six months or longer.

The assistance is intended to provide a one-off contribution towards an applicant's financial expenditure incurred as a result of the long-term illness.

INFORMATION REQUIRED:

PERSONAL DETAILS

NAME:		**DATE OF BIRTH:**	
PERSONAL IDENTIFICATION Birth certificate, passport or driver licence number			
ADDRESS			
MAILING ADDRESS			
EMAIL			
PHONE			
WERE YOU EMPLOYED BEFORE AUGUST 2016? **PLACE OF EMPLOYMENT AND YOUR JOB TITLE?** (We are asking for this to ensure your illness is not connected to your place of work)	◯ YES ◯ NO		
DO YOU HAVE HEALTH INSURANCE? If yes, please provide details of the company and policy (This is required to help determine your eligibility to the Community Health Assistance Fund)	◯ YES ◯ NO		

INFORMATION REQUIRED:

PERSONAL DETAILS

DETAIL OF ILLNESS (This is required to give the Assessor and panel an overview of your illness)	
DID YOU SEEK MEDICAL ADVICE?	◯ YES ◯ NO
MEDICAL PRACTITIONER	
DATES VISITED	

PLEASE PROVIDE BANK STATEMENTS AND RECEIPTS TO SUPPORT.

EXPENDITURE INCURRED

August 2016 - August 2017	Details	Date	Amount $
DOCTOR APPOINTMENTS			
SPECIALIST COSTS			
PRESCRIPTIONS AND MEDICINES			
LOSS OF INCOME			
OTHER COSTS OR FINANCIAL LOSS			
TOTAL			

INFORMATION REQUIRED:

OTHER SOURCES OF FUNDS

Organisation	Details	Date	Amount $
DID YOU RECEIVE ANY FINANCIAL ASSISTANCE FROM WORK AND INCOME?			
DID YOU RECEIVE ANY FINANCIAL ASSISTANCE FROM ACC?			
DID YOU RECEIVE ANY FINANCIAL ASSISTANCE FROM AN INSURANCE COMPANY?			
DID YOU RECEIVE ANY FINANCIAL ASSISTANCE FROM YOUR EMPLOYER?			
OTHER COMMENTS			
TOTAL VALUE OF FUNDS			**$**

CHECK LIST

COMPLETED APPLICATION FORM	◯
PERSONAL IDENTIFICATION Certified copy of birth certificate, passport or driver's licence if online submission (Justice of the Peace can certify them). Or Council staff can sight your original documents if submitting application by hand.	◯
COMPLETED GENERAL PRACTITIONER REFERRAL FORM	◯
ALL APPLICABLE RECEIPTS, INVOICES AND BANK STATEMENTS	◯
ANY OTHER DOCUMENTATION YOU DEEM RELEVANT	◯

IMPORTANT INFORMATION:

NOTE: You can apply on behalf of a dependent who fits the criteria and have incurred a loss because of their sickness. Any assistance you receive will be a contribution to your validated expenditure. This fund has been established jointly by Hawke's Bay Regional Council and Hastings District Council. Neither council has any legal obligation or liability to provide compensation. The results of the application process will be final, there is no review process provided. You may be contacted by the Assessor if further information is required.

GENERAL PRACTITIONER REFERRAL FORM

Please ensure you attach a completed Doctor Referral form to this application. Please note that all expenditure associated with this application, including the Doctor Referral, are the responsibility of the applicant. However if your application is approved then the Doctor Referral costs will be covered by the fund. If you are under severe financial hardship please contact the Community Health Assistance Team at **CHA@hdc.govt.nz** regarding the cost involved in getting the Doctor Referral form completed.

YOUR PRIVATE INFORMATION

I give my consent for my medical records provided by my General Practitioner to be collected, stored, used and disclosed to assist my application for Community Health Assistance. This information is being sought in order to verify whether you qualify for assistance from the Community Health Assistance Fund.

The information collected will only be used or disclosed for the purposes of the application assistance process. Information will be disclosed to the Assessor; the members of the Panel and will be shared with Community Assistance partners. Failure to provide the requested information may affect the outcome of your application.

I give consent to the Assessor and members of the Panel to talk to my insurer and employer from the time between August 2016 and August 2017.

I understand that I have the right to see and correct any personal information the Assessor and Community Assistance Panel may have about me.

Please note, personal information will be electronically stored by Hastings District Council in a secure location that only the Community Assistance Team can access for a time period of ten years, and then destroyed. All personal information in hard copy will be stored by Hastings District Council in a locked container that only the Community Assistance Team can access for a time period of ten years and then destroyed.

DECLARATION

The information provided by me is true and correct. If found to be incorrect, my application may be revoked and any monies granted to me will need to be refunded.

SIGNED: ....

NAME OF APPLICANT: .... **DATE SIGNED:** ....

COMMENTS	

SIGNED: ....

CHIEF EXECUTIVE OFFICER

PLEASE PRINT, SIGN THIS FORM AND:

DELIVER IN PERSON TO:

Community Health Assistance Team
Hastings District Council, 207 Lyndon Road East, Hastings 4122;

POST TO:

Community Health Assistance Team Hastings District Council, Private Bag 9002, Hastings 4156

OR SCAN AND EMAIL TO: CHA@hdc.govt.nz

HAWKE'S BAY REGIONAL COUNCIL

HASTINGS DISTRICT COUNCIL