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**Hospital Allowance**

**Application Form**

When you are on transfer from your base hospital, or when admitted to a hospital more than 100 km from your current residence, you’re entitled to an allowance of $20/night of your stay. This is a contribution toward the extra costs incurred or for lost income.

**When filing this form please attach your discharge papers or have it signed by your CF fieldworker, CF specialist nurse or charge nurse of the ward.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PWCF details:** | | | | | | | | | | |  | |  | |
| Name: | | | | |  | | | | | | Birth date: | |  | |
| Address: | | | | |  | | | | | |  | |  | |
|  | | | | |  | | | | | | Email: | |  | |
| City: | | | | |  | | | | | | Phone: | |  | |
| Postcode: | | | | |  | | | | | | CF Branch: | |  | |
|  | | | | |  | | | | | |  | |  | |
| **Applicant:** | | | | |  | | | | | | Relationship: | |  | |
| Address: | | | | |  | | | | | |  | |  | |
| (If different from above) | | | | |  | | | | | | Email: | |  | |
|  | | | | | | Phone: | |  | |
|  | | | | |  | | | | | |  | |  | |
| **Details of Application** | | | | | | | | | | | Application date: | | |  |
| Hospital check-in date: | | | | | | | |  | | | Discharge date: | | |  |
| Hospital: | | | |  | | | | | | | | | | |
| Signature of applicant: | | | | | | | |  | | | | | | |
|  |  |  | Have you attached a copy of the discharge papers? If not available, please have your hospital stay verified by the CF specialist nurse, your fieldworker or the charge nurse of the ward. | | | | | | | | | | | |
|  |  |  |
|  |  |  |
| **Verification:** | | | | | | | | |  | | | |  | |
| Name: | | | |  | | | | | Position held: | | |  | | |
| Signature: | | | |  | | | | | | | | | | |
|  | | | |  | | | | | | | | | | |
| **Details of Payment:** | | | | | | | | |  | | | |  | |
| Payment Method: | | | | | |  | Direct Deposit | | | Account No: | | \_ \_ - \_ \_ \_ \_ - \_ \_ \_ \_ \_ \_ \_ - \_ \_ \_ | | |
|  | | | | | |  |  | | |  | |  | | |
| Your claim will be dealt with as quickly as possible and the grant can be deposited directly into your bank account. **Receipt/s as well as proof of bank account name and number must be submitted along with this form** **(eg bank statement, screenshot of name and account number).**  **Please note:** we accept no responsibility for payments going astray if you provide incorrect bank details. A maximum of 14 days stay in hospital will be paid.  Please either email this form to [admin@cfnz.org.nz](mailto:admin@cfnz.org.nz) or mail (with discharge papers or verification) to; **Office Manager, CFNZ, PO Box 110 067, Auckland Hospital, Auckland 1148.** | | | | | | | | | | | | | | |