



BRITISH COLUMBIA ASSOCIATION OF PEOPLE WHO STUTTER

(BCAPS) A registered non-profit charity.

FUNDING APPLICATION FORM

Financial Assistance for Stuttering Treatment

BCAPS will respect the confidentiality of all the information supplied on this form.

IDENTIFYING INFORMATION

DATE: _____

APPLICANT NAME: _____

ADDRESS: _____

_____ POSTAL CODE: _____ TELEPHONE: _____

AGE: (IF UNDER 18): _____

INCOME INFORMATION (all money or credit obtained for a month)

GROSS WAGE	TAX	C.P.P.	U.I.C.	PENSION	OTHER	NET INCOME
APPLICANT	\$ _____	_____	_____	_____	_____	\$ _____
OR PARENTS OR GUARDIAN	\$ _____	_____	_____	_____	_____	\$ _____

EXPENSES (for a month)

Rent/Mortgage	\$ _____	Child Care	\$ _____	Lessons	\$ _____
Property Taxes	_____	School Expenses	_____	Donations	_____
Repairs/Furnishing	_____	Medical	_____	Loan Payments	_____
Hydro	_____	Medication	_____	Credit Card Payments	_____
Water	_____	Toiletries	_____	Life Insurance	_____
Telephone	_____	Auto Repairs	_____	Savings	_____
House Insurance	_____	Gas/Oil Maintenance	_____	Entertainment	_____
Groceries	_____	Auto Insurance	_____	Holidays	_____
Food eaten out	_____	Public Transit	_____	Other	_____
Clothing	_____	Newspapers/Magazines	_____	Total Expenses	\$ _____
Laundry/Cleaning	_____	Children's Allowance	_____	Net Income (less total expenses)	\$ _____

I have health benefits available from my employer that can subsidize the cost of speech therapy YES NO

I have funds available from friends and family YES NO

I have looked into assistance from government funding YES NO

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STUTTERING TREATMENT PROGRAM ATTENDING (or planning to attend)

NAME OF TREATMENT CENTRE: _____

ADDRESS: _____

POSTAL CODE: _____ TELEPHONE: _____ FAX: _____

DATES OF TREATMENT: _____

CONTACT PERSON AT TREATMENT CENTRE: _____

FINANCIAL INFORMATION (ESTIMATED)

COST OF TREATMENT: \$ _____

COST OF ACCOMMODATION: \$ _____

COST OF MEALS: \$ _____

COST OF INCIDENTALS: \$ _____

COST OF TRAVEL: \$ _____

TOTAL: \$ _____

OTHER SOURCES OF FUNDING

FROM EMPLOYER: \$ _____

FROM SELF: \$ _____

FROM HEALTH PLAN: \$ _____

FROM OTHER: \$ _____

TOTAL: \$ _____

INTENDED USE OF FUNDS FROM THE BRITISH COLUMBIA ASSOCIATION OF PEOPLE WHO STUTTER:

The British Columbia Association of People Who Stutter (BCAPS) will respect the confidentiality of all the information supplied on this form and will make it available only to our Board of Directors for the sole purpose of evaluating this funding application. An incomplete application may or may not be processed. BCAPS will only provide financial assistance to residents of British Columbia.

CERTIFICATION

I hereby certify that, to the best of my knowledge, the information entered on this form is correct.

SIGNED: _____ DATE: _____

WITNESS (unrelated): _____ DATE: _____

WITNESS ADDRESS: _____ TELEPHONE: _____

Witness relationship to applicant _____

RETURN FORM TO: **British Columbia Association of People Who Stutter**
12674 15th Avenue, White Rock BC V4A 1K3
tel/fax 1-888-301-BCAP(2227)
E-mail: Anthony_Intas@telus.net