



REQUEST FOR FUNDING APPLICATION

Date of Request: _____

Name of Individual who is Deafblind: _____

Street Address: _____

City: _____ Postal Code: _____

Telephone Number: () _____

Date of Birth: _____

Name of Individual Making Request
(If different from above): _____

Relationship to Deafblind Individual: _____

Was the Deafblindness present at birth? YES NO

If NO, at what age was the Deafblindness identified? _____

Are the Deafblind individual and/or his/her family a member
of the Canadian Deafblind and Rubella Association? YES NO

Purpose or nature of the requested funds (Intervention, equipment, etc.)

Total Purchase Price: \$ _____

Total Amount of Funding Requested: \$ _____

When is the money required by? _____

Identify any alternate funding agencies involved or approached:

Government Funding Source: _____

Municipal Social Services: _____

Private Insurance: _____

Service Clubs: _____

Other Agencies: _____

Equipment or Service Supplier Name: _____

Contact Person: _____

Street Address: _____

City: _____ Postal Code: _____

Telephone: () _____

Fax: () _____

Equipment or Service Supplier Name: _____

Contact Person: _____

Street Address: _____

City: _____ Postal Code: _____

Telephone: () _____

Fax: () _____

Pre-approval guidelines for requests completed by and forwarded to committee: _____

Dated: _____

To be completed by C.D.B.R.A. Funding Approval Committee:

Amount Requested: \$ _____

Amount Approved: \$ _____

Date Requested: _____

Date Approved: _____

Reason for partial funding or rejection:

