We're here to help. Here's what we need to know:

Application Checklist:

Please ensure your application is complete with all supporting documents before submitting. **We regret that applications with any missing information or documents will not be considered.**

Here's what we need included:

- ☐ Your complete, signed application.
- ☐ A referral letter from the child's healthcare professional confirming the medical or developmental diagnosis and the need for equipment/service/product and how it supports the overall treatment plan.
- ☐ Current Notice of Assessment (NOA) from Revenue Canada from each adult (household) contributor that shows net income or Canada child benefit tax (CCTB) statement that shows net family income (T4 slips, T1 summaries will NOT be accepted).
- ☐ Other supporting documents from the checklist provided regarding your request.

Please keep copies of all documents for your records. We are unable to return documents. Please ensure your application and supporting documents are **included together** with your request. **Please do not send documents separately.**

For Variety office use only:

Date Received:
CHD#
APP#
P.O.#
Approval/Denial Date:
Approval Amount For:
Grant Date(s):
Notes:

Child's personal information:

PHN = Personal Health Number

Child's Last Name:		
First Name:		☐ Male ☐ Female
Birth Date (mm/dd/yyyy):	PHN (Care Card):	
Home Address:		
City:	Postal Code:	

Diagnosed Special Need(s):

Medical category - contributing conditions/circumstances of child (check all the apply).

- ☐ Allergy/Asthma
- ☐ Audiology
- ☐ Biochemical Disease
- ☐ Cardiology
- ☐ Cleft & Craniofacial
- ☐ Dermatology
- ☐ Endocrinology & Diabetes
- ☐ Gastroenterology
- ☐ Medical Genetics & Genetic Disorders
- ☐ Mental Health
- ☐ Nephrology (Kidneys)
- ☐ Neurosciences (Neurology)
- ☐ Oncology, Haematology & BMT
- ☐ Ophthalmology
- ☐ Orthopaedics
- ☐ Pain
- ☐ Urology

Developmental - please check all that apply.

- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Austism Spectrum Disorders
- ☐ Fetal Alcohol Spectrum Disorders
- ☐ Intellectual Disability
- ☐ Learning Disability

Primary Diagnosis:
Secondary Diagnosis:
Have you received funding from Variety in the past? Y ☐ / N ☐ Year:

Parent/Guardian Information:

1. Parent/Guardian Last Name:		
First Name:		
Home Address:	City:	Postal code:
Email:		
Telephone Home:	Telephone Cell:	

2. Parent/Guardian Last Name:	
First Name:	
Email:	
Telephone Home:	Telephone Cell:
Relationship to parent/guardian 1:	
Address (if different from above):	

List all household members who live in home (including parents/caregivers, siblings, grandparents). For those who contribute to the child financially, a copy of their NOA is required. If parents are separated, and still contributing, an NOA is also required.

Names of household family members	Relationship to Child	Occupation	Employer
Parent 1			
Parent 2			

Healthcare Professional Referral Info:

(Referral Letter confirming diagnosis must be attached)

Name:		
Title/Professional Designation:		
Agency/Hospital Name:		
Address:	City:	Postal code:
Telephone:	Fax:	
Email:		

Request Information:

Variety will consider up to two (2) requests once per year. If you have more than one request, please list in order of priority. Please note: your service provider cannot be the same as your referral.

Request from Variety: Please ensure all details are included.

1. Equipment/Service/Product Description: Tutoring	Total cost of this item:
Vendor/Service Provider Name: Learning Disabilities Society	
Service Provider Designation/Qualification (if applicable):	
Address: 3292 E Broadway,	City: Vancouver, BC, Postal code: V5M 1Z8
Telephone: 604.873.8139	Fax:
Email: info@ldsociety.ca	
If applicable: Length of sessions in minutes:	Cost per session:
Total number of sessions:	

2. Equipment/Service/Product Description:	Total cost of this item:
Vendor/Service Provider Name:	
Service Provider Designation/Qualification (if applicable):	
Address:	City: Postal code:
Telephone:	Fax:
Email:	
If applicable: Length of sessions in minutes:	Cost per session:
Total number of sessions:	

Other Funding Information:
(Please name other charities accessed or accessing)

Employer Extended Healthcare	Y☐ / N☐	Amount:	Status:
At Home Program	Y☐ / N☐	Amount:	Status:
MCFD (Including Autism/CSYN)	Y☐ / N☐	Amount:	Status:
Healthy Kids	Y☐ / N☐	Amount:	Status:
Pharmacare	Y☐ / N☐	Deductible:	Maximum:
Other Charity 1:	Y☐ / N☐	Amount:	Status:
Other Charity 2:	Y☐ / N☐	Amount:	Status:
Other:	Y☐ / N☐	Amount:	Status:

Total funding amount requesting from Variety: $ 1500

Consent, Confidentiality & Authorization:

Variety - the Children's Charity of British Columbia respects and upholds an individual's right to privacy. Please refer to our Privacy Code of Ethics. Your child's information/application will be maintained as confidential, secure record.

If deemed necessary by Variety, for the purpose of determining eligibility for Variety funding and programs or for the purpose of meeting my child's needs, I give consent to Variety to contact those included in this application.

If necessary to secure cost sharing or partnership funding, I give consent to Variety to share file information with potential partnership funders.

I, _____, parent/guardian to (child's name) _____ hereby agree to the above, that the information included in this application is accurate and complete to the best of my knowledge and that I have read and understand Variety's requirements and eligibility for funding requests.

**Please feel free to provide an introductory letter about your child/family situation (optional).*

Signature:

Date:

Please send complete applications with support documents together to:
Email to: heart.fund@variety.bc.ca **Mail to:** 4300 Still Creek Drive, Burnaby BC, V5C 6C6