

<b>Child Information</b>		
<b>First Name</b>	<b>Last Name</b>	<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-binary <input type="checkbox"/> None of the above. I identify as:
<b>Date of Birth</b>	<b>PHN</b>	<b>Have you received funding from Variety in the past:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Year:
<b>Address</b>		<b>City</b>
<b>Province</b>	<b>Postal Code</b>	<b>Main Diagnoses/Conditions:</b>

<b>Diagnosed Special Need(s) – Medical and Developmental: Check all that apply</b>		
<input type="checkbox"/> Medical & Genetic Disorders	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Cleft & Craniofacial
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Endocrinology & Diabetes
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Nephrology (Kidneys)	<input type="checkbox"/> Neurosciences (Neurology)
<input type="checkbox"/> ADHD	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Oncology, Hematology & BMT
<input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Audiology	<input type="checkbox"/> Pain
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Seeking Diagnosis
<input type="checkbox"/> Learning Disability (Q Ministry Designation)	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Others:

<b>Legal Guardian Information</b>			<input type="checkbox"/> Current NOA or CCB Attached
<b>GUARDIAN #1 Name</b>	<b>Relationship to child</b>	<b>Phone</b>	<b>Cell Phone</b>
<b>Address (if different from child)</b>	<b>City</b>	<b>Province</b>	<b>Postal Code</b>
<b>Occupation &amp; Employer:</b>		<b>Email</b>	

<b>GUARDIAN #2 Name</b>	<b>Relationship to child</b>	<b>Phone</b>	<b>Cell Phone</b>
<b>Address (if different from child)</b>	<b>City</b>	<b>Province</b>	<b>Postal Code</b>
<b>Occupation &amp; Employer:</b>		<b>Email</b>	

Please list all other children in the household:

Please check if this child has been helped by Variety

1. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
2. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
3. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_
4. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Referral letter cannot be from the same vendor providing the services and quote. Please have them include as much information as possible regarding the child's symptoms and behaviours in the detailed referral letter.

<b>Health Care Professional Referral Info</b>			<input type="checkbox"/> Detailed Referral Letter Attached
Name		Title/Professional Designation	
Agency/Hospital/Organization Name			
Address	City	Province	Postal Code
Telephone Ext:	Fax No.	Email	

Variety will consider up to two (2) requests per year. If you have more than one request, please list in order of priority.

<b>Funding Request #1</b>			<input type="checkbox"/> Quote/Therapy Plan Attached
Equipment/Service/Product Description			Total Cost
Vendor/Service Provider Name			
Address	City	Province	Postal Code
Telephone	Email		
If applicable:			
Length of sessions (in minutes):		_____	
Total number/frequency of sessions:		_____	
Cost per session:		_____	

<b>Funding Request #2</b>			<input type="checkbox"/> Quote/Therapy Plan Attached
Equipment/Service/Product Description			Total Cost
Vendor/Service Provider Name			
Address	City	Province	Postal Code
Telephone	Email		
If applicable:			
Length of sessions (in minutes):		_____	
Total number/frequency of sessions:		_____	
Cost per session:		_____	

Other Applicable Funding Information			
Employer Extended Healthcare	Y <input type="checkbox"/> / N <input type="checkbox"/>	Amount:	Status:
At Home Program	Y <input type="checkbox"/> / N <input type="checkbox"/>	Amount:	Status:
MCFD (Including Autism/CSYN)	Y <input type="checkbox"/> / N <input type="checkbox"/>	Amount:	Status:
Pharmacare	Y <input type="checkbox"/> / N <input type="checkbox"/>	Deductible:	Maximum:
Other Charity:	Y <input type="checkbox"/> / N <input type="checkbox"/>	Amount:	Status:
Other:	Y <input type="checkbox"/> / N <input type="checkbox"/>	Amount:	Status:

Would you be willing to share how Variety has helped your family?  Yes  No

**Consent, Confidentiality & Authorization**

Variety – the Children’s Charity of British Columbia respects and upholds an individual’s right to privacy. Your child’s information/application will be maintained as a confidential and secure record.

If deemed necessary by Variety for the purpose of determining eligibility for Variety fund ing and programs or for the purpose of meeting my child’s needs, I give consent to Variety to share file information with potential partnership funders.

**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. Variety is unable to fund any child under 6 who received government autism funding. In addition, we are unable to pay for any items/ services you obtain prior to approval in writing.**

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

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.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

**Signature:**

**Date:**

Please keep copies of all documents for your records. We are unable to return documents.

Please ensure your application and supporting documents are **included** with your request.

**PLEASE DO NOT SEND DOCUMENTS SEPARATELY.**

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