Canadian Deafblind Association

CDBA NATIONAL SUPPORT FUND
APPLICATION FORM

Name of individual who is deafblind: _____

Name of person making request (if different from above): _____

Relationship to individual who is deafblind: _____

Street Address: _____

City/Town: _____ Postal Code: _____

Telephone: _____ Email: _____

Amount of funding being requested: $ _____

Provide a detailed cost breakdown and describe how the funds will be used (services, equipment, fees, travel):

_____

_____

_____

Other funding sources contacted for assistance and results:

1. _____

2. _____

Amount individual or family will contribute: $ _____

Date: _____ Signature of Applicant: _____

Please forward the completed application form to the CDBA National office either by:

Email: info@cdbanational.com
Mail: 1860 Appleby Line, Unit 14, Burlington, Ontario Canada L7L 7H7
Fax: (905) 331-2043

For additional information please call the CDBA National office toll free at 1-866-229-5832
Additional forms available on the CDBA National Website at **www.cdbanational.com**

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COMMITTEE USE ONLY

Amount of Funding Approved by the National Support Fund Committee: $ _____

Date: _____ Signature of Committee Chair: _____