HEWLETT COURT SHELTERED HOUSING
APPLICATION FORM
FOR PERMANENCY OR SHORT STAY

The information you provide in this form will help us determine whether we can meet your needs for a prospective future stay.
To ensure your application can be properly considered, it is important that you (or someone assisting you) complete the form carefully and accurately.

Name of Applicant:	**Date of Birth:**	**Age:**
Address of Applicant: **Post Code:**		
Telephone Number(s):	**National Insurance Number:**	
Applicant's GP Surgery & Telephone Number: **NHS Number (10-digit number, usually found on prescription):** _____		

Next of Kin (Contact in an Emergency)	**Next of Kin 2 (To be contacted if NOK1 is unavailable)**
Name: _____	**Name:** _____
Relationship: _____	**Relationship:** _____
Telephone(s): _____ _____	**Telephone(s):** _____ _____
Address: _____ _____ _____	**Address:** _____ _____ _____
Email: _____	**Email:** _____

***We need a minimum of 2x contacts for each applicant in the event of an emergency.**

Does the applicant agree to a trial stay of one or two weeks? *(Depending on how the applicant can manage, we may have to contact Next of Kin to collect the applicant if there is a risk to their health, safety, or well-being)*	YES / NO
Does the applicant agree to be temporarily registered with our local GP Surgery? (*if not in the Bury area)*	YES / NO

Please tick whichever is applicable [√]		
I am fully mobile.	I sometimes need help	I am not mobile
I walk unaided.	I walk with a stick or frame.	I use a wheelchair to get around.
I can dress/undress.	I can partly dress.	I find dressing difficult
I take medication myself and find it works well.	I sometimes struggle with taking my medication.	I find it difficult to take my medication and need help.
I am generally in good health.	I am not always in good health	I have ongoing medical needs
I do my own laundry.	I do some laundry but struggle.	I do not do my own laundry.
I have symptoms of incontinence.		YES / NO
I have been diagnosed with cognitive disorder by a Health Practitioner?		YES/ NO
If taking **medication**, please provide a copy of your prescription when you hand in the completed form. This is very important.		

Additional **Medical conditions/allergies** we need to be aware of (continue on a separate sheet if necessary).

Do you have any Dietary needs?

Do you have a DNAR (Do Not Resuscitate) form with your GP? **Yes / No** (please circle)

Freemasonry:
Lodge Name:

Lodge Number:

Name of Freemason:

Relationship:

Lodge Certificate

Those eligible are East Lancashire Freemasons and their dependents.

This application is supported by:

Lodge No:

Almoners Signature:

Telephone No:

Date:

Declaration

I confirm that, to the best of my knowledge, the information given on this form is true and accurate.

Applicant Print Name: _____

Signature: _____ **Date:** _____

or

Signed on Behalf of: (please print name) _____

Signature: _____ **Date:** _____

Relationship to applicant: _____

Thank you for taking the time to fill in this form.