*Confidential*

**DONNINGTON HOSPITAL TRUST**

**Application for an Almshouse**

**Please read NOTES FOR THE GUIDANCE OF APPLICANTS before completing this form.**

Donnington Hospital Trust is a registered charity. Selection is based on the need of suitably qualified applicants.

*Data protection. The information that you give us on this form will not be used for any purpose other than helping the Trustees and staff to consider and process your application. It will not be given to any other organisation.*

**PLEASE ANSWER ALL QUESTIONS.**
**WE CANNOT PROCESS INCOMPLETE APPLICATIONS**

Please circle your preferred location: Bray / Bucklebury / Donnington / Iffley

| | **Applicant** | **Spouse (if applicable)** |
|---|---|---|
| **Mr/Mrs/Miss** | ……………………………………. | …………………………………….. |
| **Surname** | ……………………………………. | ……………………………………. |
| **First Names** | ……………………………………. | ……………………………………. |
| **Date of Birth** | ……………………………………. | ……………………………………. |
| **Address** | ……………………………………. | ……………………………………. |
| | ……………………………………. | ……………………………………. |
| | ……………………………………. | ……………………………………. |
| **Telephone Number** | ……………………………………. | ……………………………………. |
| **Mobile Number** | ……………………………………. | ……………………………………. |
| **Email Address** | ……………………………………. | ……………………………………. |
| **Previous address** | …………………………………… | ……………………………………. |
| | …………………………………… | ……………………………………. |
| | …………………………………... | ……………………………………. |
| **Was your previous accommodation:** | **rented / owned** (please delete accordingly) | |
| **National Insurance Number** | ……………………………………. | ……………………………………. |

## DETAILS OF YOUR PRESENT ACCOMMODATION

**1.** Do you own the house you are living in? **Yes / No**

**2. If you rent:**

Do you rent the house you are living in? **Yes / No**

If you rent your house, how much is your monthly rent £………………….

Who do you rent from:

- Private landlord ☐
- Family ☐
- Housing Association ☐
- Local authority ☐

**3.** Do you share? Kitchen ☐

- Bathroom ☐
- None ☐

**4.** Do you live in a:

- House ☐
- Bungalow ☐
- Flat ☐
- Mobile home ☐

**5.** How long have you been living in your current home? ☐ years ☐ months

**6.** Do you have any pets? **Yes / No**

If **yes**, please provide details: ….…………………………………………………..

……………………..……………………………………………………………………..

# PRINCIPAL APPLICANT

## HEALTH (applicant) **Tick as many boxes as you feel applicable**

| **General Health** | | **Hearing** | | **Eyesight** | | **Mobility** | |
|---|---|---|---|---|---|---|---|
| Poor | ☐ | Poor | ☐ | Poor | ☐ | Poor | ☐ |
| Fair | ☐ | Fair | ☐ | Fair | ☐ | Fair | ☐ |
| Good | ☐ | Good | ☐ | Good | ☐ | Good | ☐ |
| | | Hearing aid | ☐ | Partially sighted | ☐ | Wheelchair | ☐ |
| | | Deaf | ☐ | Blind | ☐ | Frame | ☐ |
| | | | | | | Sticks | ☐ |
| | | | | | | Handrails needed | ☐ |
| | | | | | | Grabrails needed | ☐ |

Disabilities ……………………………………………

……………………………………………………………..

……………………………………………………………..

Are you currently undergoing or awaiting any medical treatment **Yes / No**

Please give brief details ………………………………………………………………………….

Do you, or have you, received help from the community mental health team **Yes / No**

Please give brief details ………………………………………………………………………….

…………………………………………………………………………………………………….

Do you currently have a care package? **Yes / No**

Do you smoke? **Yes / No**

Do you drive? **Yes / No** If **yes**, do you own a car? **Yes / No**

Have you ever had a criminal record? **Yes / No**

Do you work? **Yes / No** If **yes**, is this full time/part time/volunteer

# SECOND APPLICANT (if applicable)

**HEALTH (spouse or partner)** **Tick as many boxes as you feel applicable**

| General Health | | Hearing | | Eyesight | | Mobility | |
|---|---|---|---|---|---|---|---|
| Poor | ☐ | Poor | ☐ | Poor | ☐ | Poor | ☐ |
| Fair | ☐ | Fair | ☐ | Fair | ☐ | Fair | ☐ |
| Good | ☐ | Good | ☐ | Good | ☐ | Good | ☐ |
| | | Hearing aid | ☐ | Partially sighted | ☐ | Wheelchair | ☐ |
| | | Deaf | ☐ | Blind | ☐ | Frame | ☐ |
| | | | | | | Sticks | ☐ |
| | | | | | | Handrails needed | ☐ |
| | | | | | | Grabrails needed | ☐ |

Disabilities ……………………………………………

………………………………………………………..

………………………………………………………..

Are you currently undergoing or awaiting any medical treatment **Yes / No**

Please give brief details …………………………………………………………………….

Do you, or have you, received help from the community mental health team **Yes / No**

Please give brief details …………………………………………………………………….

………………………………………………………………………………………………….

Do you currently have a care package? **Yes / No**

Do you smoke? **Yes / No**

Do you drive? **Yes / No** If **yes**, do you own a car? **Yes / No**

Do you have any criminal convictions? **Yes / No**

Do you work? **Yes / No** If **yes**, is this full time/part time/volunteer

## NEXT OF KIN

Name ……………………………………………………………………………………………

Address ………………………………………………………………………………………..

Telephone …………………………………………. Relationship …………………………

## RELATIVES

Which members of your family live nearest? (Please give two if possible)

Name ……………………………………………………………………………………………

Address ………………………………………………………………………………………..

Telephone …………………………………………. Relationship …………………………..

Name ……………………………………………………………………………………………

Address ………………………………………………………………………………………

Telephone ……………………………………….. Relationship …………………………..

## POWER OF ATTORNEY

Have you granted Power of Attorney to anyone? ☐ **Yes** ☐ **No**

If **yes,** to who? ……………………………………………………………………………

Address ……………………………………………………………………………………....

………………………………………………………………………………………………..

Telephone …………………………………………. email ………………………………….

**FINANCIAL DETAILS**
THIS SECTION MUST BE COMPLETED IN FULL

| | | |
|---|---|---|
| State retirement pension | £ | monthly |
| Occupational pension | £ | monthly |
| Total of any other pensions | £ | monthly |
| Interest on savings and investments | £ | monthly |
| Earnings | £ | monthly |
| Benefits (please specify) | £ | monthly |
| Other income (please specify) | £ | monthly |
| **Total Income** | £ | monthly |

Are you in receipt of any state benefits? ☐ Yes ☐ No

| | |
|---|---|
| **Current market value (approx) of your house/flat (if you own property)** | £ |
| **Savings or other capital** | £ |

**Do you share the freehold of your house with anyone else?** ☐ Yes ☐ No
**If yes, please provide details**

Signed: ………………………………………………………………
I declare that the above information is true to the best of my knowledge

If we asked, could you provide proof? ☐ Yes ☐ No

We may ask for a letter from a referee/solicitor to confirm the details above.

**Trustees are obliged to ask questions about your financial situation.**

**If we require written personal references to accompany your application, who could we ask**?

Name …………………………………………………………………………………………

Address ………………………………………………………………………………………

…………………………………………………………………………………………………...

Relationship to you (not family) ………………………………………………………..

Name …………………………………………………………………………………………

Address ………………………………………………………………………………………

…………………………………………………………………………………………………...

Relationship to you (not family) ………………………………………………………..

**Please state fully your reason for wanting to move into an almshouse.** (Please continue on a separate sheet if necessary).

Please answer as fully as possible to assist us in assessing your need.

**Please state below how you heard of or knew of the Donnington Hospital Trust.**

Please post your completed application form to:

Trust Office
Donnington Hospital Trust
1 Groombridge Place
Donnington
Newbury
Berkshire RG14 2JQ

Tel No: 01635 551530
E-mail: office@donningtonhospital.com

Please make sure that you have signed the financial details section.

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***OFFICE USE ONLY:***

*Interview:*

*Trustee Interview/NOK:*

*References:*

*Medical:*

*Right to Rent:*

*Offer:*

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**MEDICAL CONSENT FORM**

Please provide the name, address and telephone number of your GP:

Name ……………………………………………………………...……………………………...

Address ………………………………………………………………………………………..

………………………………………………………………………………………………..

Telephone No: ………………………………………………………………………………

May we approach your GP(s) if medical information is required concerning your suitability for almshouse warden-controlled accommodation?

☐ Yes ☐ No

**Please note: Trustees can only consider your application if you agree to allow the Trust to approach your GP. We only require information about whether, in the GP's opinion, you are able to look after yourself independently and, if not, the level of care you require. Our Wardens cannot provide nursing or personal care**.

Signed:………………………………… (applicant)

Name: …………………………………

Date: ………………………………….