Trinity Hospital Leicester

50 Western Boulevard, Leicester LE2 7BU

APPLICATION TO BECOME A RESIDENT AT TRINITY
INITIAL APPLICATION FORM

THE CHARITY COMMISSION REQUIRES US TO INVESTIGATE THE PERSONAL CIRCUMSTANCES OF APPLICANTS FOR SCHEMES LIKE TRINITY. THE PERSONAL DATA SUPPLIED ON THIS FORM, AND OTHER INFORMATION RELATING TO YOUR APPOINTMENT OR CARE MANAGEMENT, WILL BE HELD ON FILE. SOME DETAILS MAY BE CHECKED WITH RELEVANT ORGANISATIONS BUT NONE WILL BE DISCLOSED FOR ANY INAPPROPRIATE PURPOSE. YOU MAY SEE YOUR PERSONAL INFORMATION ON REQUEST.

PERSONAL DETAILS

APPLICANT

SURNAME (MR/MRS/MISS) .....

FORENAMES .....

ADDRESS .....

.....POST CODE.....

TELEPHONE . .....

MOBILE ……

E-MAIL ADDRESS ……

DATE OF BIRTH .....

MARITAL STATUS .....

IF YOU ARE APPLYING FOR A DOUBLE FLAT, PLEASE GIVE YOUR PARTNER'S:

SURNAME…….

FORENAMES ..... DATE OF BIRTH .....

ABOUT YOUR PRESENT ACCOMMODATION

DO YOU OWN YOUR PRESENT HOME? ....**YES**/**NO**.

IF NO, GIVE NAME & ADDRESS OF

LANDLORD .....

.....

HOW MUCH RENT DO YOU PAY £..... PER WEEK/MONTH

HOW LONG HAVE YOU LIVED AT THIS ADDRESS .....

ARE YOU ON OTHER HOUSING LISTS? ……..

IF YES, PLEASE INDICATE WHICH LISTS

.....

DO YOU OWN A CAR .... **YES**/**NO**

ARE YOU OR YOUR PARTNER IN ANY PAID EMPLOYMENT.... **YES**/**NO**

GIVE BRIEF DETAILS .....

.....

PRESENT STATE OF HEALTH (give brief details) .....

.....

PLEASE GIVE FULL DETAILS OF ANY HELP & CARE YOU CURRENTLY RECEIVE, WHETHER FROM STATUTORY / VOLUNTARY AGENCIES OR FAMILY / FRIENDS, E.G. MEALS ON WHEELS, HOME HELP, ETC.

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.....

NEXT OF KIN

NAME .....

ADDRESS .....

..... TEL NO. .....

RELATIONSHIP TO YOU .....

ANY OTHER INFORMATION YOU WISH TO GIVE IN SUPPORT OF YOUR APPLICATION (CONTINUE ON THE BACK OF THIS SHEET IF NECESSARY)

.....

.....

HOW SOON DO YOU WISH TO MOVE .....

MEDICAL REFERENCE – PLEASE GIVE THE NAME OF YOUR DOCTOR. WE MAY ASK FOR A REPORT ON YOUR HEALTH AND ABILITY TO LOOK AFTER YOURSELF.

NAME OF DOCTOR……...

ADDRESS……

……

CHARACTER REFEREES - PLEASE GIVE THE NAMES OF TWO REFEREES

NAME ..... NAME .....

ADDRESS ..... ADDRESS .....

....

HOW LONG KNOWN ..... HOW LONG KNOWN .....

WE MAY WRITE TO THE REFEREES FOR REFERENCES.

DECLARATION

I DECLARE THAT ALL THE INFORMATION I HAVE GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNED .....

DATE .....

FALSE INFORMATION COULD LEAD TO THE LOSS OF ACCOMMODATION
INFORMATION YOU HAVE GIVEN WILL BE TREATED IN STRICT CONFIDENCE.

PLEASE RETURN THE COMPLETED APPLICATION FORM TO:

CLERK TO THE GOVERNORS
TRINITY HOSPITAL
50 WESTERN BOULEVARD
LEICESTER LE2 7BU

OR:

E-MAIL THE FORM TO:

Trinityhospital@btconnect.com