

PERSONAL DETAILS							
Title		First name		Surname			
Address							
Town		County		Postcode			
Phone				BT	<input type="checkbox"/>	Other	<input type="checkbox"/>
Date of birth				Marital status			

OTHER PERMANENT RESIDENTS IN HOUSEHOLD		
Surname	First names	DOB

NEXT OF KIN					
Title		First name		Surname	
Address					
Town		County		Postcode	
Phone				Relationship	

TYPE OF DWELLING								
House	<input type="checkbox"/>	Bungalow	<input type="checkbox"/>	Flat/Maisonette	<input type="checkbox"/>	Sheltered	<input type="checkbox"/>	
Floor (Ground/First/Other)				Door entry system	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Council/Housing Assoc Rent	<input type="checkbox"/>	Private rent	<input type="checkbox"/>	Owner/occupier	<input type="checkbox"/>			

APPLICANT'S FINANCIAL STATUS									
<i>Is the applicant in receipt of either or both:</i>									
Council Tax Rebate	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Income Support	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<i>NB: Single Occupancy Rebate does not apply</i>									

HOW WOULD YOU LIKE TO MAKE PAYMENTS?					
Direct Debit	<input type="checkbox"/>	Post office	<input type="checkbox"/>	Post	<input type="checkbox"/>

DOCTOR'S DETAILS			
Name		Phone no	
Address			

MEDICAL DETAILS						
	<i>Applicant</i>			<i>Other Resident</i>		
	Good	Fair	Poor	Good	Fair	Poor
Eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPECIFIC MEDICAL PROBLEMS						

DOES THE APPLICANT RECEIVE ANY OTHER HEALTH AND DOMICILIARY SERVICES?							
<i>If so, please tick days</i>	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Home Care Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Visitor/ District Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FRIENDS, RELATIVES, NEIGHBOURS <i>(People who can be called in case of emergency)</i>			
Name and address	Tel no	Relationship	Keyholder?
Is a key safe required?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is a Key safe already installed?		CODE: <input type="text"/>	

FOR OFFICE USE ONLY			
Applicant referred by	Social Services <input type="checkbox"/>	Area Health Authority <input type="checkbox"/>	Other <input type="checkbox"/>
ID No		Date processed	
Notes			