the INDEPENDENT LIVING
Great Hospital

Application Form for Residency

Reference No (office use only) -

Name of Applicant 1

Name of Applicant 2 (if applicable)

January 2024

Personal Details

Address	Home Telephone Number Mobile Telephone Number E-mail Address

Applicant 1	Applicant 2 (if applicable)
1 Nationality	2 Nationality
1 Place of Birth	2 Place of Birth
1 Date of Birth / Age	2 Date of Birth /Age
1 Previous occupation	2 Previous occupation

Applicant 1	Applicant 2 (if applicable)
1 National Insurance Number	2 National Insurance Number
1 NHS Number	2 NHS Number

Status (please circle)

Married Civil Partnership Single Divorced Separated Widowed

Accommodation

Are you currently:

1. Renting a privately owned property
2. Renting a Local Authority property
3. Renting a Housing Association property
4. Living in a home that you own

If you have selected 4 above, is this property mortgaged? Yes / No

Financial Details

Please indicate if weekly / monthly/ annual

Gross rent you pay for the property you live in £.....

Income

State retirement pension £.....

Other pensions £.....

Savings £.....

Investments £.....

Housing Benefit £.....

Other Benefits £.....

Attendance Allowance £.....

I certify that this is an accurate statement of my / our income & capital

Signed..... Signed.....

Date..... Date.....

Medical Details

Do either of you have an illness or disability? Yes / No

If YES, please give details below

Do (either of) you have a sight impairment, not corrected with glasses? Yes / No

Do (either of) you have a hearing impairment, not corrected with an aid? Yes / No

Can you (both) safely climb stairs? Yes / No

Do (either of) you use a walking aid? Yes / No

Name, Address & Telephone Number of your current doctor

We may need to contact your GP as part of our assessment for residency

I certify that this is a true record of my medical conditions

Signed..... Signed.....

Date..... Date.....

Social Life

Please indicate below your interests & any activities that you take part in

Please give any supporting information regarding your application

Next of Kin / Or someone who can be contacted in an emergency

Please supply two names

1 Name..... Relationship.....

Address.....

..... Post Code.....

Landline Telephone Number.....

Mobile Telephone Number.....

E-mail Address.....

2 Name..... Relationship.....

Address.....

..... Post Code.....

Landline Telephone Number.....

Mobile Telephone Number.....

E-mail Address.....

Lasting Power of Attorney

Please give details below

How did you hear about the Great Hospital?

Please indicate below

The Great Hospital collects and processes personal data relating to applications for residency and is committed to being transparent about how it collects, stores and uses that data and in meeting its data protection obligations under data protection legislation including the General Data Protection Regulation (GDPR). Please read our privacy notice for residency applicants for further information on how and why we collect and use your personal information, both during and after the application process. This can be found here; http://www.greathospital.org.uk/wp-content/uploads/2018/05/GDPR-Privacy-Notice-for-Residency-Applicants_LP.pdf