

**CONFIDENTIAL**

**SALTER'S HILL CHARITY**

**APPLICATION FORM**

**PLEASE USE BLOCK CAPITALS. THIS FORM SHOULD BE COMPLETED IN FULL AND RETURNED WITH ALL AVAILABLE REPORTS TO:  
MRS. GILL SACKETT, SENIOR MANAGER, SALTER'S HILL CHARITY,  
SALTER'S HILL BARN, KEEPERS COTTAGE, FALCON LANE, LEDBURY,  
HEREFORDSHIRE. HR8 2JN**

SALTER'S HILL CHARITY

<b>SURNAME</b>			<b>FORENAMES</b>	
<b>D.O.B.</b>	<b>AGE</b>	<b>SEX</b>	<b>RELIGION</b>	<b>NATIONALITY/ETHNIC ORIGIN</b>

**ADDRESS:**

**TEL:**

**POST CODE:**

**HOME ADDRESS (if different from above):**

**TEL:**

**POST CODE:**

**NAME & ADDRESS OF NEAREST RELATIVE:**

**RELATIONSHIP:**

**TEL:**

**POST CODE:**

**LOCAL AUTHORITY (County Council, Borough etc)**

**NAME AND ADDRESS OF SOCIAL WORKER:**

SALTER'S HILL CHARITY

**TEL:**

**POST CODE**

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**FAMILY PROFILE FATHER**

<b>SURNAME:</b>	<b>FORENAMES:</b>	<b>AGE:</b>
<b>OCCUPATION:</b>	<b>HEALTH:</b>	<b>MARITAL STATUS:</b>

**ADDRESS:**

**TEL:**

**POST CODE:**

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**FAMILY PROFILE MOTHER**

<b>SURNAME:</b>	<b>FORENAMES:</b>	<b>AGE:</b>
<b>OCCUPATION:</b>	<b>HEALTH:</b>	<b>MARITAL STATUS:</b>

**ADDRESS:**

**TEL:**

**POST CODE:**

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**DETAILS OF SIBLINGS & OTHER MEMBERS OF THE HOUSEHOLD:**

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**WHEN IS PLACEMENT REQUIRED?**

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**HAS ANY APPLICATION FOR A SERVICE EVER BEEN REFUSED? Y/N**

**IF YES, PLEASE GIVE DETAILS:**

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**DETAILS OF ALL EDUCATIONAL ESTABLISHMENTS ATTENDED (Please enclose reports if available)**

DATES	DETAILS

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**DETAILS OF ALL PREVIOUS PERIODS OF RESIDENTIAL CARE (HOSTEL, GROUP HOME, VOLUNTARY ORGANISATION, SUPPORTED LIVING ETC).**

DATES	DETAILS

**DETAILS OF ALL PREVIOUS WORK AND TRAINING OPPORTUNITIES:**

DATES	DETAILS

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**HEALTH**

**MEDICAL DIAGNOSIS** .....

**SYNDROME (if applicable)** .....

**IMMUNISATION HISTORY (with dates if possible)**

POLIO		MUMPS	
TETANUS		TUBERCULOSIS	
DIPHTHERIA		WHOOPIING COUGH	
MEASLES		SMALLPOX	

**DETAILS OF CURRENT MEDICATION:**

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.....

**SPECIAL PRECAUTIONS – CONTRA-INDICATIONS – SENSITIVITY TO DRUGS – ALLERGIES etc:**

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**MENSTRUATION – DATE OF ONSET and HOW MANAGED :**

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**DIET – ANY SPECIAL REQUIREMENTS?**

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**NAME AND ADDRESS OF MEDICAL PRACTITIONER:**

**TEL:**

**POSTCODE:**

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**NAME AND ADDRESS OF CONSULTANT:**

**TEL:**

**POSTCODE:**

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**DETAILS OF MAJOR ILLNESSES (including mental health problems), TREATMENT, INVESTIGATIONS etc:**

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**SEXUAL DEVELOPMENT AND AWARENESS:**

**Onset of puberty**

**Details of sexual counselling/education**

**Degree of awareness**

**Difficulties**

**Contraception etc**

**Other**

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**PEN PORTRAIT (Personality, likes/dislikes, mobility, significant relationships, phobias, hobbies, level of social competence) :**

**SOCIAL ASSESSMENT**

PLEASE TICK IF TOTALLY INDEPENDENT; IN AREAS OF DIFFICULTY PLEASE ELABORATE.

1. Uses cutlery appropriately
  2. Will dress taking into consideration weather and occasion
  3. Is able to attend to toileting needs
  4. Attends to personal hygiene needs
  5. Can look after clothes
  6. Takes care of possessions
  7. Has due regard for the possessions of others
  8. Understands spoken instructions and information
  9. Can express needs through speech
  10. Tells the time
  11. Reads
  12. Writes
  13. Visits nearby places unsupervised
  14. Is aware of road safety
  15. Uses public transport
  16. Understands the value of money
  17. Chooses clothes and knows personal measurements
  18. Prepares simple snacks
  19. Organises own leisure
  20. Plays simple games
  21. Plays team games
  22. Can use potentially dangerous tools safely
  23. Works without supervision
  24. Works as a member of a group
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**FINANCIAL CIRCUMSTANCES**

**1. BENEFITS, PENSIONS, ALLOWANCES:**

TYPE OF BENEFIT	REF. NO	APPOINTEE	WEEKLY AMOUNT

**2. CAPITAL ASSETS (ie. Savings, investments, bank deposits, property etc)**

TYPE OF ASSET	ADDRESS OF BANK, BUILDING SOC. etc	ACCOUNT NO.	AMOUNT

**3. DETAILS OF TRUAT FUNDS, BENEVOLENT ASSOCIATIONS etc THAT MAY APPLY NOW OR IN THE FUTURE:**

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**SIGNATURE OF APPLICANT**

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**SIGNATURE OF PERSON COMPLETING THIS FORM**

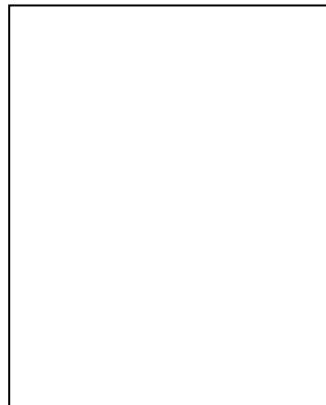
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**RELATIONSHIP TO APPLICANT**

.....

**DATE**

.....



**RECENT PHOTOGRAPH**

**NOTES**

**1. In admitting a person to residential care, individual needs and the aims of the Home must be considered. It is therefore of paramount importance that this form is completed with this in mind, thus making possible a smooth transition and integration into the Home.**

**2. It is assumed, unless you inform us to the contrary, that we may approach direct any person who has been involved in the care and treatment of the applicant.**

**3. If you are furnishing original reports/assessments/records and wish them to be returned, please indicate accordingly and unless you advise us to the contrary, we assume we can take photo-copies of them.**

**4. In view of the scarcity of residential placements we appreciate that you may well have made application to other organisations (voluntary or otherwise) and we operate in very close association with them, we would very much appreciate being informed. This will in no way invalidate the application but it would allow us to liaise with them in the matter of who is best equipped to, or able to respond to the application.**

**5. For the purposes of identification it would be appreciated if you would supply a passport type photograph of the applicant for our records.**

**6. It would greatly assist us in dealing with this application if we could be regularly updates (in writing) of any significant change in circumstances.**

**7. All admissions will be for a probationary period of 4 weeks in the first instance. This will ensure that the Home is able to offer the most appropriate level of support.**

**8. The progress of all residents is subject to an annual review by those involved in the person's care.**