

Francis House Application for Residence

STRICTLY CONFIDENTIAL

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ASSISI COMMUNITY CARE EST.1985

FRANCIS HOUSE

APPLICATION DATE _____ ADMISSION _____

PERSONAL DETAILS

NAME _____

ADDRESS _____

POSTCODE _____

DATE OF BIRTH _____ AGE _____

NI NUMBER _____

NATIONALITY _____

MARITAL STATUS _____ RELIGION _____

ANY CHILDREN? _____

ANY BROTHERS AND/OR SISTERS? _____

NEXT OF KIN

NAME _____

ADDRESS _____

POSTCODE _____

PHONE _____ FAX _____

RELATIONSHIP _____

EDUCATION & INTERESTS

WHAT IS YOUR LEVEL OF EDUCATION?

PRIMARY

GRAMMAR

SECONDARY

COLLEGE

COMPREHENSIVE

UNIVERSITY

WHERE DID YOU STUDY? _____

ANY HOBBIES/INTERESTS? _____

ANY SPORTS? _____

DO YOU HAVE A DRIVING LICENCE? YES NO

HAVE YOU BEEN BANNED FROM DRIVING? YES NO

IF YES, WHEN? _____

LENGTH OF BAN _____

ANY OUTSTANDING LEGAL ACTION/FINES?

YES NO

IF YES, PLEASE GIVE BRIEF DETAILS OF CONVICTION OR SENTENCE

ANY PREVIOUS CONVICTIONS? YES NO

IF YES, PLEASE GIVE BRIEF DETAILS

PROBATION OFFICER (IF APPLICABLE)

NAME _____

ADDRESS _____

POSTCODE _____

BENEFITS

IF YOU RECEIVE STATE BENEFIT PLEASE INDICATE BELOW:

IB IS DLA

DATE OF LAST PAYMENT _____

HOW DO YOU GET YOUR BENEFIT?

GIRO ORDER BOOK

BANK ACCOUNT

MEDICAL

HAVE YOU HAD ANY PROBLEMS WITH

- ALCOHOL GAMBLING VIOLENCE
 DRUGS BED WETTING

PLEASE GIVE DETAILS, IE FROM WHAT AGE

IF YOU TICKED ALCOHOL WOULD YOU DESCRIBE YOURSELF AS AN

- ALCOHOLIC HARD DRINKER
 HEAVY DRINKER PROBLEM DRINKER

IF YOU TICKED DRUGS ARE YOU REGISTERED AS AN ADDICT/
CASUAL USER?

- YES NO

HAVE YOU SUFFERED FROM

- EPILEPSY SCHIZOPHRENIA HIV
 DEPRESSION BREAKDOWN TB MEMORY LOSS

ARE YOU ALLERGIC TO ANYTHING? YES NO

IF YES, PLEASE GIVE DETAILS

PRESENTLY TAKING MEDICATION? YES NO

PLEASE LIST

HAVE YOU HAD OR ARE YOU CURRENTLY HAVING

PSYCHIATRIC TREATMENT? YES NO

IF YES, PLEASE DESCRIBE

GENERAL PRACTITIONER

NAME _____
ADDRESS _____

POSTCODE _____
PHONE _____

EMPLOYMENT

WHAT TYPE OF WORK HAVE YOU PREVIOUSLY DONE?

- PROFESSIONAL MANAGER NON-MANUAL
 CLERICAL SEMI-SKILLED UNSKILLED
 ARMED FORCES SELF-EMPLOYED OTHER

JOB TITLE _____

DATES OF LAST PERIOD OF WORK

HOW WOULD YOU BENEFIT FROM YOUR STAY WITH US?

WHAT SUPPORT COULD YOU CONTRIBUTE TO OUR COMMUNITY
AT FRANCIS HOUSE?

- CLEANING DECORATING GARDENING
 KITCHEN LAUNDRY RECYCLING

DETAILS OF PREVIOUS HELP (NAME & LOCATION OF CENTRE)

TREATMENT CENTRE _____
DRY HOUSE _____
COMMUNITY _____
HOSTEL _____
HOSPITAL _____
OTHER _____

The personal information that you provide will be handled by Assisi Community Care in accordance with the Data Protection Act 1998. It will be used as part of the process of assessing your application. Your information will not be used for any other purpose and will not be disclosed to any other parties except where this is otherwise required by law.

SIGNATURES

APPLICANT SIGNATURE _____
NAME _____
DATE _____
PERSON SUPPORTING APPLICATION SIGNATURE _____
NAME _____
DATE _____

REFERRAL AGENCY

NAME _____
ADDRESS _____

POSTCODE _____
PHONE _____ FAX _____
FUNDING AUTHORITY/PROVIDER _____

REFERRAL SOURCE (PLEASE TICK)

- | | |
|---|---|
| <input type="checkbox"/> CRIMINAL JUSTICE AGENCY | <input type="checkbox"/> SOCIAL SERVICES |
| <input type="checkbox"/> SELF-REFERRAL | <input type="checkbox"/> MENTAL HEALTH TEAM |
| <input type="checkbox"/> GP/PRIMARY CARE | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> GENERAL HOSPITAL (INC A&E) | |
| <input type="checkbox"/> LIAISON SERVICES (GEN HOS PSYCH) | |

REFERRAL AGENCY COMMENTS

PLEASE ATTACH ANY ADDITIONAL INFORMATION ON SEPERATE SHEETS. IF NECESSARY, CONTINUE OVERLEAF.