

HAWTHORNE TRUST LIMITED

**APPLICATION FOR ADMISSION TO CHARTON MANOR
AS AN ASSISTED LIVING RESIDENT**

Applicant

Name (Mr/Mrs/Miss/Ms/Other) _____

Address _____

_____ Post Code _____

Home telephone _____ Mobile (if any) _____

E-mail (if any) _____

Date of birth _____ Nationality _____

Occupation (or former occupation) _____

Spouse's name and occupation (if any) _____

Next of Kin or, if no Next of Kin, authorised representative

Name (Mr/Mrs/Miss/Ms/Other) _____

Relationship to Applicant _____

Address _____

_____ Post Code _____

Home telephone _____ Mobile (if any) _____

E-mail (if any) _____

Referees

Please give details of 2 referees (not relatives), one of whom is a Christian Scientist.

(We are likely to contact them so please ask for their permission to give us their details.)

1. Name (Mr/Mrs/Miss/Ms/Other) _____

Address _____

_____ Post Code _____

Home telephone _____ Mobile (if any) _____

E-mail (if any) _____

Relationship to Applicant (i.e. friend, fellow church member etc) _____

Is the Referee a Christian Scientist? Yes/No How long have you known this person? _____

2. Name (Mr/Mrs/Miss/Ms/Other) _____

Address _____

_____ Post Code _____

Home telephone _____ Mobile (if any) _____

E-mail (if any) _____

Relationship to Applicant (i.e. friend, fellow church member etc) _____

Is the Referee a Christian Scientist? Yes/No How long have you known this person? _____

Status as a Christian Scientist

Mother Church membership no. _____ Year Joined _____

Are you a branch church member? Yes/No

If yes, please state the branch and year joined _____

Have you had Class Instruction? Yes/No

If yes, please state Teacher and year attended class _____

Practitioner preference

Please give details of the Christian Science practitioner you would like the management to call if required.

Name (Mr/Mrs/Miss/Ms/Other) _____

Address _____

_____ Post Code _____

Home telephone _____ Mobile (if any) _____

E-mail (if any) _____

Care Plan information

In order to determine whether Hawthorne Trust can meet your needs and develop a care plan for you, an assessment will be made before you come. This is normally made by the Christian Science Nursing Manager or her Deputy.

Are you able to take ordinary care of yourself without assistance? Yes/No

If no, what help do you require? _____

Have you any physical or mental disorder of which the House needs be aware? Yes/No

If Yes, please specify _____

Please list your interests and hobbies and any special activity you would like to pursue as a resident of Charton Manor _____

Please tell us briefly why you would like to come to Charton Manor: _____

Return Address

Your first 2 months at Charton Manor are on a trial basis. This is a time when you, your representative, if any, and the Trust can determine whether or not your needs can be met at Charton Manor. Please give the address you would return to if you do not remain at Charton Manor after that period.

Address _____

_____ Post Code _____

Finance and property

Our current charges are enclosed. Are you able to meet the cost of the fees yourself? Yes/No

If No, would you like advice about obtaining financial aid? Yes/No

[Some applicants who can't afford the fees and who are eligible for state benefit may also be eligible for some charitable top-up funding.]

On termination of residency, fees are payable until all personal furniture and effects are removed from the room.

Please provide a list of items you might wish to bring with you. A copy of the list should be kept by your Next of Kin or, if no Next of Kin, your authorised representative.

While staying at Charton Manor, you qualify for and are entitled to be paid Attendance Allowance. If you are not able to claim yourself or have nobody to help you claim, do you need Charton Manor to help you to claim Attendance Allowance? Yes / No

Declaration by applicant

I apply for admission to Charton Manor as a Resident. I understand that all persons living in Charton Manor rely entirely on Christian Science for healing; that no medical attention is provided; and that no medical examinations are made in the house, except as required by law.

I agree:

- to respect the privacy of other residents;
- to live in harmony with other residents;
- to observe the rules of the House and any direction given to me by the Manager;
- if I have a problem, to report it to the Manager;
- to pay the fees for my residence each month in advance, by bank Standing Order;
- to give 2 months' notice if I decide to leave Charton Manor.

Signature _____ (Applicant)

Date _____

The services provided include:

- Assistance with Personal Care to include dressing, bathing, manicure and pedicure
- All meals and drinks in either the Dining Room or tray service in room
- Laundry service
- Daily room cleaning and weekly linen change
- Audio CDs of the Bible lesson and Christian Science periodicals
- Transport to church on Sunday mornings and Wednesday evenings
- Weekly country drives in the surrounding district
- Use of communal areas in the house and garden
- Associate membership of Hawthorne Trust Ltd.

They do not include:

- Christian Science nursing care or incontinence supplies – service of visiting Christian Science nurse, if required, paid for separately
- Fees of Christian Science practitioners
- Services of a hairdresser or chiropodist
- Dry cleaning
- Private telephone and line rental
- Specialist transport
- Liability for private property in excess of £500.

APPLICATION FOR ADMISSION TO CHARTON MANOR FOR RESIDENTIAL CARE

Appendix 1

Terms of residence at Charton Manor

Hawthorne Trust Ltd. agrees to provide accommodation at Charton Manor for a fee payable monthly in advance by bank standing order. Hawthorne Trust will give 2 months' notice of any increase in fees.

For a temporary absence for a holiday or nursing care, fees will be reduced by the cost of food and laundry. Each resident is allowed up to 2 weeks' temporary absence from the House annually without charge (assuming that this is a 'recreational' absence). If there is a need to go into the nursing wing, the status of your residential room will be reviewed on a monthly basis. On the termination of residence, fees will be payable for 2 months or until all personal furniture and effects are removed from the room, whichever is later, but no responsibility will be taken for items left beyond 2 months.

A resident may be asked to leave Charton Manor on one month's notice –

- a) if he or she fails to comply with the rules, principles and practices of the House or otherwise behaves in a manner detrimental to the peace and wellbeing of the House, its residents and staff;
- b) if his or her mental or physical state deteriorates beyond the capacity of staff to deal with consistent with the status of the House as a non-nursing care home.

Subject to the above, every effort will be made to accommodate any special requirements of the resident, within the resources of Charton Manor and its staff.

Complaints

Complaints should not be discussed with members of the staff but taken directly to the Manager or a Board member. In the event of a serious complaint being unresolved, the resident may contact the Care Quality Commission, Southeast Office, Citigate, Gallowgate, Newcastle NE1 4PA. Telephone 03000 616161.

Residents' Wills

In the event of death, the procedure should take into account the known wishes of the resident. The location of every resident's Will should be included in the resident's record file. No resident, Board member, manager or staff should witness a resident's will unless in extreme emergency. Residents are recommended to arrange an Enduring Power of Attorney in appropriate cases. Residents are also encouraged to sign an Advance Directive/Living Will to state their wishes in case they become unable to communicate or to take part in decisions about their condition. A sample of such a Directive is attached as Annex 2.

APPLICATION FOR ADMISSION TO CHARTON MANOR AS A RESIDENT

Appendix 2

ADVANCE DIRECTIVE

I of Charton Manor, Gorse Hill, Farningham, Kent DA4 0JT make this advance directive to state my wishes in case I become unable to communicate or otherwise cannot take part in decisions about my care.

1. Medical treatment in general

My wishes concerning medical treatment in general are:

- I do not wish to receive medication or treatment of any kind,
- I wish any medical intervention to be kept to an absolute minimum.

2. Medical treatments in particular

My wishes concerning particular medical treatments or investigations are:

- I wish no part of my body to be used after my death for research or transplant purposes.

HEALTH CARE PROXY

I appoint the following person to take part in decisions about my medical care on my behalf, and to represent my views about them, if I am unable to do so.

Name (Mr/Mrs/Miss/Ms) _____

Address _____

Post Code _____

Telephone (day) _____ Telephone (night) _____

Mobile (if any) _____ E-mail (if any) _____

I wish this person to be consulted about:

- any medication to be given to me,
- any medical intervention to be undertaken, and
- to be involved in those decisions, and I wish those caring for me to respect the views that this person expresses on my behalf.

This document remains effective until I make clear that my wishes have changed.

Signed _____ Date _____

In the presence of:

Signature of witness _____

Name of witness (please print) _____

Address _____

Post Code _____