 Adaptations and Independent Living Grant Application Form

Employee ref: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **1. About the former employee** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Title | | First Name | | | | | | | | | | | | | | | | | | Surname | | | | | | | | | | | | | | | | | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode | |  | | |  | | |  | | |  | |  | |  |  |  |  | | | | | | | | | | | | | | | | | | | | | |
| Home telephone number  *(include dial code)* | |  | | | | | | | | | | | | | | | Mobile number | | | | | | | | |  |  | |  |  | | |  | |  | | |  | |
| Email address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| NI Number | |  | | |  | | |  | | |  | |  | |  |  |  |  | |  | | | |  | |  |  | |  |  | | |  | |  | | |  | |
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| Date of Birth  *dd mm yyyy* | |  | | |  | | |  | | |  | |  | |  |  |  |  | |  | | | |  | |  |  | |  |  | | |  | |  | | |  | |
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| Dates of  Employment | | From To  *You may need to provide evidence of this if your employment record is not held on our database* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Place/Department | | *Where did you last work?* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **2. Who is the request for?**  *Please tick relevant box and include all documents requested as evidence (see guidance notes).* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Former Employee | | |  | | |  | | Spouse or Partner  *Provide marriage certificate, and proof of co-habitation* | | | | | | | | | | |  | |  | Dependent child *(under 18 or in full-time education if over 18)*  *Provide long form birth certificate* | | | | | | | | | | | | | | |  | | |
| **2.1 About you** *the applicant (if not the former employee)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title | | First Name | | | | | | | | | | | | | | | | | | Surname | | | | | | | | | | | | | | | | | | | |
| Address  *(if different the former employee)* | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode | |  | | |  | | |  | | |  | |  | |  |  |  |  | | | | | | | | | | |  |  | | |  | |  | | |  | |
| Home telephone number  *(include dial code)* | |  | | | | | | | | | | | | | | | Mobile number | | | | | | | | |  | | | | | | | | | | | | | |
| Email address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| NI Number | |  | | |  | | |  | | |  | |  | |  |  |  |  | |  | | | |  | |  |  | |  |  | | |  | |  | | |  | |
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| Date of Birth  *dd mm yyyy* | |  | | |  | | |  | | |  | |  | |  |  |  |  | |  | | | |  | |  |  | |  |  | | |  | |  | | |  | |
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| **4. Adaptations or Equipment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Describe your illness or disability | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| How does your illness or disability affect your quality of life?  *\*provide evidence of this from a medical professional* | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of adaptation or equipment you need  How would this improve your quality of life?  \**give full details and provide evidence from a medical professional* | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP name | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surgery Address | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of occupational therapy or full care needs assessment | | |  | | |  | | |  | |  | | Who has carried out this assessment?  \*provide evidence of this | | | | | | | | | | |  | | | | | | | | | | | | | |
| Have you applied for a Disabled Facilities Grant? | | | Yes | | | | | No | | |  | | Has your application for a Disable Facilities Grant been rejected?  \* provide evidence of this | | | | | | | | | | | Yes | | | No | | |  |  | |  | |  | | |
| Is there a shortfall in the amount offered? | | | Yes | | | | | No | | |  | | If yes, how much is the shortfall? | | | | | | | | | | |  | | | | | |  |  | |  | |  | | |
| Cost of equipment or adaptation  *\*2 written quotes must be included* | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **4.1 GDPR Consent** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The following consents are required for us to process your application for and, if successful, provide you with the **Adaptations and Independent Living Grant.** You have the right to withdraw this consent at any time. If you do not give consent or if you withdraw your consent, we will no longer be able to process your application or provide you with the grant.  **Please tick the boxes and sign below**   * I consent to my health data being processed by Baily Thomas Provident Fund for the purposes of: * Processing my application in order to decide about whether to provide the requested support or assistance to me; and * Providing me with that support or assistance * I consent to my health data being shared with the **Baily Thomas Provident Fund’s retained GP** for the purpose of carrying out an assessment for the Baily Thomas Provident Fund to decide about whether to provide the requested support or assistance to me   Signature………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | **5. Privacy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Baily Thomas Provident Fund is committed to protecting your privacy. We will use the information you have supplied on this form to process your application and to update the Trustees’ records relating to the employee beneficiaries. Full details of how we process your personal data can be found in our Privacy Policy. To request a printed copy please contact us using the details below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **6. Declaration** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * I declare the information I have provided in this form is, to the best of my knowledge, accurate and true and will update the Baily Thomas Provident Fund if my information changes. * I understand that the information I have provided will be used to process this application and to update beneficiary records. * I understand that to comply with the legal reporting obligations for trustees, basic personal information will be disclosed to HMRC for inclusion on the Trust Register. * I understand that the information I have provided will be processed in accordance with the Baily Thomas Provident Fund Privacy Policy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Your Signature (applicant) | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | |
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| **Your completed form should be returned to:**  **Baily Thomas Provident Fund, Mansfield Business Centre, Ashfield Avenue, Mansfield NG18 2AE**  **Contact us:**  Telephone: 01623 473290  Email: enquiries@bailythomasprovidentfund.org.uk  Web: [www.bailythomasprovidentfund.org.uk](http://www.bailythomasprovidentfund.org.uk) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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