CHESTHELP

APPLICATION FOR ASSISTANCE

PLEASE COMPLETE THIS FORM WITH YOUR HEALTH PROFESSIONAL

FULL NAME …….....

HOME PHONE NO……MOBILE NO.....

EMAIL ADDRESS……..……..…….....

YOUR ADDRESS…….....…….....

POST CODE…… DATE OF BIRTH…….....

YOUR USUAL EMPLOYMENT…….....

DOES YOUR ILLNESS PREVENT YOU FROM WORKING?.....IF YES, FOR HOW LONG?.....

WHICH STATE BENEFITS DO YOU RECEIVE, OR HAVE YOU APPLIED FOR?

…….....

DO YOU LIVE ALONE?..... HOW MANY DEPENDANTS LIVE WITH YOU?.....

DOES ANYONE IN YOUR HOUSEHOLD RECEIVE AN INCOME?.....

NAME OF THE HEALTH PROFESSIONAL REFERRING YOU…….....

THEIR PHONE NO……..... YOUR HOSPITAL NUMBER…….....

MY MAIN ILLNESS IS TB……. COPD……..OTHER…….....

OTHER HEALTH CONDITIONS YOU WISH US TO KNOW ABOUT…….....

…….....

I AM APPLYING FOR (PLEASE TICK AS APPROPRIATE):

NUTRITIONAL SUPPORT ……..... HEATING ALLOWANCE .....

OTHER (PLEASE SPECIFY)…….....

I HAVE READ AND UNDERSTOOD THE INFORMATION ON THE REVERSE OF THIS FORM AND HAVE AGREED WITH MY HEALTH PROFESSIONAL(S) THAT THE HELP THAT CHESTHELP CAN GIVE ME WILL RELIEVE MY MEDICAL CONDITION.

I CONSENT TO MY HEALTH PROFESSIONAL(S) DISCUSSING MY ILLNESS(ES) AND HOUSEHOLD SITUATION WITH THE CHESTHELP TEAM IN ORDER TO SUPPORT THIS APPLICATION. A COPY OF OUR PRIVACY NOTICE CAN BE FOUND AT www.chesthelp.org

I AGREE TO INFORM YOU IF MY CIRCUMSTANCES CHANGE AND I NO LONGER REQUIRE CHESTHELP'S SUPPORT. I UNDERSTAND THAT ASSISTANCE, IF PROVIDED, WILL BE FOR A MAXIMUM PERIOD OF SIX MONTHS AND CAN BE WITHDRAWN AT ANY TIME

APPLICANT'S SIGNATURE……..DATE…….....

SEND THIS COMPLETED FORM TO: ROB PHILLIPS – TREASURER CHESTHELP

18 STOURWOOD ROAD BOURNEMOUTH BH6 3QP 01202 250471 margrob@ntlworld.com

WHO ARE WE?

CHESTHELP IS A REGISTERED CHARITY FOUNDED IN 1947 TO HELP **TB** AND **COPD** PATIENTS SUFFERING FINANCIALLY BECAUSE OF THEIR ILLNESS.

HOW DO I QUALIFY FOR ASSISTANCE?

YOUR APPLICATION **MUST** BE SUPPORTED AND REFERRED BY YOUR HEALTH PROFESSIONAL.

YOU MUST LIVE IN THE **BH POSTAL AREA.**

YOU MUST BE SUFFERING FINANCIALLY BECAUSE OF YOUR **TB** OR **COPD** ILLNESS.

HOW DO WE HELP?

CHESTHELP CAN PAY FOR DELIVERIES OF MILK, EGGS, CHEESE, BUTTER & FRUIT JUICE – NUTRITION ESSENTIAL FOR A **TB** PATIENT'S RECOVERY AND SUPPORT FOR HOUSEBOUND **COPD** PATIENTS. WE SETTLE THE BILL DIRECT WITH THE DAIRY COMPANY.

CHESTHELP CAN ALSO PROVIDE A HEATING ALLOWANCE FOR EACH OF THE TWO WINTER QUARTERS.

OCCASIONALLY, WE WILL CONSIDER OTHER REQUESTS FOR ASSISTANCE, SUPPORTED BY YOUR HEALTH PROFESSIONAL DEPENDING UPON YOUR CIRCUMSTANCES.

HOW LONG DO YOU HELP?

CHESTHELP IS A SMALL CHARITY WITH LIMITED RESOURCES SO A TIME LIMIT OF **SIX MONTHS** IS SET FOR **ALL** PATIENTS, A LITTLE LONGER FOR **TB** PATIENTS WHERE TREATMENT IS EXTENDED.

WHAT HAPPENS NEXT?

YOUR APPLICATION FORM IS SENT TO US BY YOUR HEALTH PROFESSIONAL WHO WILL DISCUSS YOUR SITUATION WITH OUR CASE OFFICER. OUR CASE OFFICER WILL USUALLY PHONE YOU FOR ANY FURTHER INFORMATION AND WILL KEEP YOU INFORMED OF THE PROGRESS OF YOUR APPLICATION.

DETAILS OF YOUR APPLICATION, **BUT NOT YOUR NAME OR ADDRESS,** ARE SENT TO OUR COMMITTEE BY EMAIL TO SEEK THEIR AGREEMENT – THIS USUALLY TAKES A FEW DAYS.

CHESTHELP IS REGISTERED WITH THE INFORMATION COMMISSIONER'S OFFICE. WE WILL ONLY DISCUSS SENSITIVE INFORMATION ESSENTIAL TO YOUR APPLICATION FOR ASSISTANCE WITH YOUR HEALTHCARE PROFESSIONAL AND SOCIAL WORKER. STRICT LEVELS OF CONFIDENTIALITY ARE MAINTAINED.

OUR DATA PRIVACY NOTICE IS AVAILABLE TO READ ON OUR WEBSITE:

www.chesthelp.org

WHAT HAPPENS IF CHESTHELP RUNS OUT OF FUNDS TO ASSIST?

CHESTHELP RESERVES THE RIGHT TO WITHDRAW ASSISTANCE AT ANY TIME, EITHER BECAUSE YOUR CIRCUMSTANCES HAVE CHANGED OR DUE TO LACK OF FUNDS.