



HAWTHORNE TRUST LIMITED

**APPLICATION FOR ADMISSION TO CHARTON MANOR  
FOR THOSE IN NEED OF RESIDENTIAL CARE**

Date admission required \_\_\_\_\_

Applicant

Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home telephone \_\_\_\_\_ Mobile (if any) \_\_\_\_\_

E-mail (if any) \_\_\_\_\_

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_

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) \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home telephone \_\_\_\_\_ Mobile (if any) \_\_\_\_\_

E-mail (if any) \_\_\_\_\_

Referees

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

1. Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home telephone \_\_\_\_\_ Mobile (if any) \_\_\_\_\_

E-mail (if any) \_\_\_\_\_

2. Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home telephone \_\_\_\_\_ Mobile (if any) \_\_\_\_\_

E-mail (if any) \_\_\_\_\_

Return address

All applicants come for a trial period of 2 months. Please give the address to which you would return if you do not remain at Charton Manor after that period

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Post Code \_\_\_\_\_

Status as a Christian Scientist

Mother Church membership no. \_\_\_\_\_ Date admitted \_\_\_\_\_

Are you a branch church member ? Yes/No

If yes, please state the branch \_\_\_\_\_

Have you had Class Instruction ? Yes/No

If yes, please state year and teacher \_\_\_\_\_

Practitioner preference

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

Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home telephone \_\_\_\_\_ Mobile (if any) \_\_\_\_\_

E-mail (if any) \_\_\_\_\_

Care Plan information

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 give any other information you think would be useful to the Trust in considering your application and creating a Care Plan for you.

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_

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.

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 Standing Order on a bank;
- to give 2 months' notice if I decide to leave Charton Manor

Signature \_\_\_\_\_ (Applicant)

Date \_\_\_\_\_

Witnessed (by the Manager or Administrator)

Name \_\_\_\_\_

Position \_\_\_\_\_

Signature \_\_\_\_\_

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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
- Library service
- 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
- Hairdressing
- Specialist transport if required
- Liability for private property in excess of £500.

# APPLICATION FOR ADMISSION TO CHARTON MANOR FOR RESIDENTIAL CARE

## Annex 1

### Terms of residence at Charton Manor

Hawthorne Trust Ltd. agrees to provide accommodation at Charton Manor for \_\_\_\_\_ (name) in room no. \_\_\_\_\_ at a cost of £\_\_\_\_\_ per week (£\_\_\_\_\_ per calendar month) 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 (currently £\_\_\_\_\_ per week)

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

Annex 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 \_\_\_\_\_