

**Hospital visitor grant scheme**

**Application form**

The Sutton Mencap Hospital visitor grant scheme has been set up to ensure that people with a learning disability living in Sutton can continue to have social contact with familiar paid carers on admission to hospital in order to minimise distress.

Please read the grant guidelines and terms and conditions before completing your application.

**Part 1. Contact information – person completing this form**

|  |  |
| --- | --- |
| Name of the person completing this form |  |
| Contact Email address |  |
| Date of application |  |
| Relationship to the person with a learning disability (e.g. family member, paid carer, manager, social worker, health professional, other) |  |

**Part 2: About the person with a learning disability**

|  |  |
| --- | --- |
| Patient’s first name(s) |  |
| Patient’s surname |  |
| Male/ female (please delete) | Date of birth |  |
| Patient’s home addressPostcode |  |
| Patient’s usual living arrangements (e.g. care home, supported living, independent living, shared lives, with parent/ family member) |  |

**Part 3: Hospital admission**

|  |  |
| --- | --- |
| Date of admission |  |
| Emergency or planned? |  |
| Name of primary physician (first and surname) |  |
| Initial diagnosis/ reason for admission |  |
| Anticipated length of stay (days) |  |

**Part 4: Care and support needs**

|  |
| --- |
| Patient’s needs: briefly explain why this person would benefit from additional paid support whilst in hospital. |
|  |
| How many hours of support per day are you applying for? |  |
| How many days of support are you applying for? |  |

**Part 5: Funding required**

|  |  |
| --- | --- |
| Total amount of grant requested | £ |
| Breakdown of costs (please list headings and costs, e.g. staff hours and rate, travel expenses, subsistence). |  |
| If successful, name of bank into which payment will be made |  |
| Account holder’s name |  |
| Account number |  |
| Sort code |  |

**Part 6: Care provider**

|  |  |
| --- | --- |
| Name of person who will be paid to provide care |  |
| Contact telephone number for care provider |  |
| Agency providing care (if applicable) |  |
| Agency/ care providers addressPostcode |  |

**Declaration**

I have read and agree to the guidelines and terms and conditions for this grant. I confirm that the information provided on this form is true and correct and I agree that if my application is successful, the money can be paid into the account details stated above.

|  |  |
| --- | --- |
| Name |  |
| Position in organisation |  |
| Date |  |

**Please e-mail your completed application to hospitalvisitor@suttonmencap.org.uk**