

Admission Form

This Admission Form is to be read in association with the terms set out in the booklet, "Resident Contract Terms", (together the "Contract").



Contract No:

White copy/Home Blue copy/Resident

The name of the Care Home Provider is: Barchester Healthcare Homes Limited

Name of Care Home: _____

Name of Resident: _____

Preferred Name: _____

Current or Last Residential Address: _____

Date of Birth: ____/____/____

NI Number: _____

Placement Type:

- ☐ Residential
- ☐ Continuing Healthcare
- ☐ Local Authority
- ☐ Nursing
- ☐ Lifestyle Choice
- ☐ Third Party Top Up

Type of Resident:

- ☐ Long Stay (permanent)
- ☐ Short Stay (temporary)

Short Stay (temporary) Resident - Complete this Section

Start Date: ____/____/____

End Date: ____/____/____

Number of Days/Nights: _____

Day Rate: £ _____

Total Fee Due before Admission: £ _____

(Number of nights x daily rate)

Note if a short term (temporary) resident's stay exceeds 28 days they will be classed as a long term (permanent) resident and the terms applicable to a long term (permanent) resident will automatically apply.

Long Stay (permanent) Resident - Complete this Section

Start Date: ____/____/____

Weekly Fee: £ _____ per Week

This will automatically increase by no more than 8% each 1st April, except in the circumstances described within the Resident Contract Terms.

Advance payment, to be paid on or before Admission:

Deposit (refundable): £ _____

(see Resident Contract Terms)

Initial Fee of: £ _____

(days from commencement to start of direct debit), _____ days

Total Fee Due before Admission: £ _____

Fees will be collected monthly in advance by direct debit thereafter, commencing 1st day of ____ month ____ year

Proof of Funding for 2 Years Provided?

- ☐ Yes
- ☐ No, but a Personal Guarantee Deed has been completed
- ☐ No, state number of months funds have been demonstrated _____

Note that in the event that the funding level supplied by a public sector commissioner is less than that required for the placement, the full fee remains payable. In the case of continuing healthcare funding, the supplementary fee is known as a "lifestyle contribution" and you agree to pay the "lifestyle contribution."

Chargeable items will be invoiced monthly and are payable on presentation of the invoice by the Resident /Guarantor/Third Party (delete as appropriate).

	Chargeable
Additional one to one care	
Chiropody	
Dental requirements (not within NHS provisions)	
Optical requirements (not within NHS provisions)	
Pharmaceutical	
Physiotherapy	
Hairdressing	
Newspapers	
Personal dry cleaning	
Staff escorts to hospitals	
Taxis and other transportation	
Other (to be specified)	

(Tick boxes where applicable)

Name of the person responsible for the fees stated below:

Relationship to Resident: _____

I confirm that I have received a copy of the Resident Contract Terms which forms part of this Contract and agree to the terms and conditions contained within this Contract.

I undertake to pay such sums properly due to the Care Home Provider on the due date and to observe such terms and conditions.

Where I am not the Resident I will use my reasonable endeavours to ensure that the Resident observes such terms and conditions.

Signature: _____

Capacity in which signing:

- ☐ Resident
- ☐ Next of Kin
- ☐ Power of Attorney
- ☐ Deputy / Guardian
- ☐ Legal Representative
- ☐ Third Party

Full Name & Address: _____

_____ Post Code: _____

Witness Signature: _____

Full Name & Address: _____

_____ Post Code: _____

Date and Place of Signing: _____

Agreed on behalf of the Care Home Provider by: _____

Signature: _____

Position: _____

Witness Signature: _____

Full Name & Address: _____

_____ Post Code: _____

Date and Place of Signing: _____