**The Royal Society For Home Relief to Incurables Edinburgh**

**Scottish Charity Number: SC004365**

The Society gives assistance to persons under state retirement age in Scotland who have ceased to work on account of having an incurable illness. The Society normally considers those who have ceased employment within the last 10 years. An allowance is given half yearly to assist in providing extra help. The Society however is not in a position to consider isolated requests to meet single emergencies.

If you wish to be considered for assistance, please read the following notes and complete the attached application form.

**Notes**:

* The Society can only consider applications from people with a chronic health problem. The following conditions (if primary cause of disability) are excluded: Alcoholism or drug abuse, Mental Illness, Learning Difficulties, Primary Epilepsy, Blindness or visual impairment, birth deformities as a primary cause of disability.
* It would help the decision-making process if as much detail as possible is given in completing this form.
* Grants are discretionary and the Directors reserve the right to exercise their discretion in every case.
* The application form must be accompanied by a letter of support from the applicant’s social worker or health care professional.

**Completed form and letter of support to be sent to:**

Azets

Exchange Place 3

Semple Street

Edinburgh EH3 8BL

Telephone No: (0131) 473-3500

**Email: SM-Charity@azets.co.uk**

**Privacy Notice**

The Society takes your privacy very seriously and has a policy that explains why and how we will store, process and secure the information you give us. Visit <https://www.scott-moncrieff.com/assets/form-files/Incurables__Privacy_Notice_Jan_2019_(002).docx> to read our Privacy Policy.

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| **APPLICATION FORM** | | | |
| **Please print clearly and complete all parts (write N /A for “not applicable” if required)** | | | |
| **PERSONAL DETAILS** | | | |
| Title | First Name | Initials | Last Name |
|  |  |  |  |
| Date of Birth |  | | |
| Address |  | | |
| Post Code |  | | |
| How long at this address? |  | | |
| Mobile phone |  | | |
| Home phone |  | | |
| Email address |  | | |

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| **HEALTH** | |
| NOTE: The Society can only consider applications from people with a chronic health problem. The following conditions ( if primary cause of disability) are excluded: Alcoholism or drug abuse, Mental Illness, Learning Difficulties, Primary Epilepsy, Blindness or visual impairment, birth deformities as a primary cause of disability. | |
| Medical condition (illness or disability) |  |
| When did this start? |  |
| How does this affect you? |  |
| Medication(s) |  |
| Name of GP |  |
| Address of GP |  |
| Telephone for GP |  |
| Please list contact details for other professionals involved in your care: e.g. consultant, specialist nurse |  |

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| --- | --- |
| **PREVIOUS EMPLOYMENT** | |
| Most recent job |  |
| Name of employer |  |
| Address of employer |  |
| How long did you work there? |  |
| Date last worked |  |
| Reason for leaving |  |

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| **LIVING CIRCUMSTANCES** | | | |
| Please tell us who you live with | | | |
| Full name | Date of Birth | Relationship to applicant | Status – in employment, in education, retired, etc. |
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| --- | --- | --- | --- |
| **YOUR HOME** | | | |
| Type of accommodation (please circle all that apply) | | | |
| Owner occupier | Mortgaged | Private Rented | Council / Housing Association |
| House | Flat | Maisonette | Other |
| Hostel | Sheltered Accommodation | Residential Home | Nursing Home |

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| --- | --- | --- | --- |
| **FINANCIAL SITUATION** | | |  |
| **NOTE: Please give all amounts below as weekly equivalents** | | |  |
| **Income** | **£** | **p** |  |
| PIP/DLA |  |  |  |
| ESA/JSA |  |  |  |
| Housing benefit |  |  |  |
| Child benefit |  |  |  |
| Occupational Pension |  |  |  |
| Any other pension |  |  |  |
| Interest / Dividends on investments (including bank and building society interest) |  |  |  |
| Any other income (subletting, boarders, other charities, etc.) |  |  |  |
| Partner’s gross earnings (excluding allowance for expenses or car allowance) |  |  |  |
| Partner’s gross income from investments or savings |  |  |  |
| Any other income |  |  |  |
|  | | |  |
| **Expenditure** | **£** | **p** |  |
| Rent less rebate |  |  |  |
| Mortgage repayment |  |  |  |
| Council tax |  |  |  |
| Heating/ energy costs |  |  |  |
| Repayments of debts / loans |  |  |  |
| Other expenditure (e.g., child care) |  |  |  |
|  |  |  |  |
| **Savings** | **£** | **p** |  |
| Balances with bank and building society accounts |  |  |  |
| Investments |  |  |  |

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| --- | --- |
| **PREVIOUS APPLICATION** | |
| Has applicant applied before? If so, is there any change in circumstances since previous application? |  |

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| **PRIVACY NOTICE**  The Society takes your privacy very seriously and has a policy that explains why and how we will store, process and secure the information you give to us. Visit <https://www.scott-moncrieff.com/assets/form-files/Incurables__Privacy_Notice_Jan_2019_(002).docx> to read our Privacy Policy. | | | |
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| **DECLARATION** | | | |
| I confirm that the information given above is correct to the best of my knowledge and I agree that the Society may make such enquiries as are necessary including contacting my GP and my last employer. I understand that the information on this form will be used to assist the Society in proceeding with this application and I hereby give consent to its use for that purpose. In particular, I authorize my doctor(s) to give such information in support of this application as may be requested by the Society’s Doctor. I undertake to advise the Directors of any improvements in my circumstances and of any change in my address.  I confirm that by submitting this application and signing this declaration I agree to the information on the form ( and any attachment) being stored in the Society’s manual filing systems and computer systems for the sole purpose of grant processing, analysis, monitoring and accounting. | | | |
| Signature of Applicant |  |  |  |
|  | | | |
| Date |  | | |
| **If the form is being signed by someone on your behalf, please provide details below** | | | |
| Name (Block Capitals) | |  | |
| Relationship to applicant | |  | |
| Your address & telephone number | |  | |
| Are you Power of Attorney? | | Yes / No | |
| Signature |  |  |  |
|  |  |  |  |
| Date |  | | |