KEN HEALTH CARE
Meeting seniors' needs
one heart at a time

KEN HEALTH CARE BURSARY APPLICATION FORM

Please note: All data included in this form is treated as private and confidential. Ken Health Care Ltd is committed to protecting and respecting your privacy. We take your privacy as nominator and the privacy of the nominee very seriously.

If you give us information on behalf of someone else, you must confirm in writing that the other person has appointed you to act on his / her behalf and has agreed that you can:

- give consent on his/her behalf to the processing of his/her personal data
- receive on his/her behalf any data protection notices
- give consent to the transfer of his/her personal data

APPLICANT DETAILS *(Person making the application on behalf of Bursary recipient / nominee)*

Circle Salutation: Mrs / Miss / Ms. Mx. Mr Dr / Prof.	**First Name:**	**Surname:**
Date of Birth: *(DD/MM/YY)*	**Home Tel:** *Incl. International Codes*	**Cell:** *Incl. International Codes*
Full Home Address including Postcode:		**Country of Residence:** **National Insurance No:**
Email:		**Employment Status or nominator *(please tick):*** Full Time Employed ☐ Part Time Employed ☐ Self Employed ☐ Unemployed ☐
Are you the nominated person's next of kin? **Yes** ☐ **No** ☐		
Relationship to nominee:		
Do you have legal guardianship, Power of Attorney or conservatorship of the nominee, their personhood, their health, their financial affairs? **Yes** ☐ **No** ☐ ***Note:*** *Legal guardianship, Power of Attorney or conservatorship documents should be submitted as further evidence in support of your application.*		

NEXT OF KIN / GUARDIANSHIP PERSONAL STATEMENT OF MEANS

This part of the application asks for details of your declared taxable income (Gross).
Please declare your income, making clear the currency in which you earn your income e.g. USD $ | UK £ | CA $ | JMD $ etc

INCOME	**AMOUNT**		**CURRENCY**
Annual Salary			
Value of Total Savings			
Monthly Pension Income			
Occupation:			
Do you currently pay for, or towards the nominee's care? Yes ☐ No ☐			
If you answered 'Yes' above, please state the average, monthly amount you pay for or towards the nominee's overall care – incl. food, meds, GP & hospital treatment?			
Please state <u>your financial reasons</u> for seeking a bursary for care of your nominee. Please use a blank sheet of paper if necessary to give as much information as possible on your financial need.			

NOMINEE DETAILS (BURSARY RECIPIENT)

Circle Salutation: Mrs / Miss / Ms. Mx. Mr Dr / Prof.	**First Name:**	**Surname:**
Date of Birth: *(DD/MM/YY)*	**Home Tel:** *Incl. International Codes*	**Gender: M / F**
Full Home Address including Postcode:		**Last Country of Residence:**
		Religion:
General Practitioner (Doctor) Address:		**General Practitioner (Doctor) Name:**
General Practitioner Email:		**General Practitioner Tel:**

MEDICAL NEEDS *(please tick all that applies)*:

Dementia / Alzheimer's diagnosed	☐	Nutrition management	☐
Diabetes / Hypertension	☐	Alcohol dependency	☐
Cancer care	☐	Tobacco dependency	☐
Cardiac anomalies / Heart Disease	☐	Recent stroke	☐
Kidney disease / Dialysis	☐	Sensory impairment *(Sight / hearing)*	☐
Bowel incontinence	☐	Wound healing / Wound prevention	☐
Urinary incontinence	☐	Post-surgery care	☐
Motor conditions *ie. Parkinson's etc.*	☐	Mental illness *incl. personality disorders*	☐

Please note: *A detailed medical report including General Practitioner's letter and assessments will be required to support your application, including cardiac and psychiatric reports.*

APPLICANT'S STATEMENT

Please tell us in short essay-style format or bullet points why you believe your nominee person should be granted a Ken Health Care bursary for respite / short-term care.

Provide as much detail as possible on the nominee's current care needs, their financial circumstances and why you believe they or their next of kin or extended family are unable to financially support their care.

Two references are required to support this application. Applications will not advance without the name and signature of endorsement by a: 1) **Medical Practitioner** (General Practitioner / Surgeon etc.) who is or has treated the nominated person *and* 2) **Pastor, Priest or Community leader**, who knows your nominee	
Referee 1 Name:	**Referee 2 Name:**
Address:	**Address:**
Office Tel:	**Office Tel:**
Cell:	**Cell:**
Email:	**Email:**
Signature: **Date:**	**Signature:** **Date:**

STATEMENT OF TRUTH

I believe that all information and facts that I have given in this form are true. I understand that Ken Health Care Ltd is legally entitled to bring action against an applicant who makes, or causes to be made, a false statement in this document, or a fraudulent bursary claim.

Applicant's Full Name:

Signature:

Date:

Please email this form and supporting evidence to: Admissions@kenhealthcare.com