**Lunch Club Application Form**

Lunch Clubs are a service for independent people over the age of 55. To obtain a place you need to be able to access the service independently. Consideration will be given to applicants who are receiving a day service or will require some assistance or support within this service.

Details of the Lunch Clubs can also be found on our website [www.ageukoldham.org.uk](http://www.ageukoldham.org.uk)

**Please complete with as much information as possible:**

|  |  |  |  |
| --- | --- | --- | --- |
| Lunch Club applied for: |  | Date of application: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Address: |  | | |
| Post Code |  | Religion: |  |
| Telephone Contact: |  | Date of Birth |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Local contact Name *(in case of emergency)* |  | Telephone: |  |
| Next of Kin Name: |  | Relationship: |  |
| Address: |  | | |
| Post Code: |  | Telephone No: |  |
| GP Name: |  | GP Contact Number: |  |
| GP Address: |  | | |
| Form completed by: |  | | |
| *If not yourself, please state relationship to applicant:* |  | | |
| *Contact Telephone:* |  | *Contact Email:* |  |
| How did you hear about this service? |  | | |

**Please answer the following questions:**

|  |  |
| --- | --- |
| 1. Do you have Social Worker?   *If yes please give name and contact details if known:* | Yes No |
| 1. Do you receive any of these services? | Home Care Private Care Day Care |
| 1. Do you have any mobility problems?   *If yes please tell us what help /aids / assistance you require:* | Yes No |
| 1. Which type of transport will you be using? | Ring and Ride Public Transport Relative Other |
| 1. Do you have any problems with your memory?   *If yes please explain what support you would need to access this service and assistance required whilst at the Lunch Club:* | Yes No |
| 1. Are you registered blind or partially sighted?   *If yes will you require assistance to move around the building / access toilet area:* | Yes No |
| 1. Do you have a hearing impairment? | Yes No |
| 1. Are you diabetic?   *If yes, are you controlled by:*    *Please list medication taken:* | Yes No  Diet Medication Insulin |
| 1. Special dietary requirements:   i.e. low fat etc |  |
| **Please describe any further information with regards to your health and details of any support you may require to access this service:** | |
|  | |

Please return this form to: Age UK Oldham, 10 Church Lane, Oldham OL1 1SA - 0161 633 0213

Or email to: [sue.fletcher@ageukoldham.org.uk](mailto:sue.fletcher@ageukoldham.org.uk) or [kryshia.winkler@ageukoldham.org.uk](mailto:kryshia.winkler@ageukoldham.org.uk)

|  |  |
| --- | --- |
| **Offical Use Only:** | |
| Applicant Name: |  |
| Date Application Processed: |  |
| Processed by: |  |
| Date applicant contacted: |  |
| Applicant Successful:  Please give details: | Yes No |
| If application was unsucessful, state reasons and action given: |  |
| Date placed on Waiting List: |  |
| Review Date: |  |
| Date Confirmation Sheet Sent Out: |  |
| Start Date Given: |  |

|  |  |
| --- | --- |
| Processing Officer Signature: |  |
| Date: |  |