

FOR OFFICE USE: DATE RECEIVED



## membership application OUT OF BOROUGH REFERRALS

Please complete, sign and bring with you on your first visit, or return to:  
**Membership, Core Arts, 1 St Barnabas Terrace, Homerton, London E9 6DJ**  
If you have any queries please call **020 8533 3500**

**ALL PARTS OF THIS FORM MARKED WITH AN \* MUST BE FILLED IN BEFORE MEMBERSHIP CAN COMMENCE.**

**\* Guidance notes helping you to fill in this application are at the back of the form**

### ★ applicant's details

SURNAME\*

FORENAME(S)\*

ADDRESS\*

POSTCODE\*

HOME TEL\*

MOBILE TEL\*

EMAIL

### ★ referrer's details

if you are **not** the applicants principle care co-ordinator or key worker then please also complete the next section giving details of those involved in the applicants care.

NAME\*

ADDRESS\*

POSTCODE\*

TEL

EMAIL

JOB TITLE\*

RELATIONSHIP TO APPLICANT\*

### ★ details of those involved in your care

Your **care co-ordinator** is the person responsible for co-ordinating your support in the community. They are usually **CPNs** (Community Psychiatric Nurses), **Social Workers** or **Community Support Workers**. If you are unsure of who they are, ask your **GP** or **Psychiatrist**.

NAME*	
ADDRESS*	
POSTCODE*	
TEL*	EMAIL
JOB TITLE*	RELATIONSHIP TO APPLICANT*

### ★ reason for application

HOW DO YOU PERCEIVE THE BENEFITS IN ATTENDING CORE ARTS?

**SECTIONS 5 AND 6 ARE TO BE COMPLETED BY THOSE INVOLVED IN THE APPLICANT'S CARE.  
SELF REFERRERS PLEASE ASK YOUR CARE COORDINATOR TO FILL THESE SECTIONS IN.**

### **★ funding details**

HAVE YOU SECURED FUNDING FOR YOUR CLIENT'S ATTENDANCE?\* yes  no

**If NO please note that funding must be agreed before membership can commence. Please refer to the Fees section of the guidance notes.**

IF YES ARE YOU PAYING VIA:\* option a (fill in section 6 below)  option b (ask for our Direct Payments form)

FOR HOW MANY DAYS PER WEEK:\* 1  2  3  4

FOR HOW MANY MONTHS?\*

### **★ invoice details**

CONTACT NAME\*

INVOICE ADDRESS\*

POSTCODE\*

TEL\*

FAX\*

REFERENCE NO. OR PURCHASE ORDER NO.\*

SIGNATURE (CARE CO-ORDINATOR)\*

DATE\*

### **★ monitoring details**

DATE OF BIRTH\*

GENDER\* male/female (delete as appropriate)

**\* Please complete the separate monitoring form**

### **★ terms and conditions\***

**To be read and signed by the prospective member.**

I am aware that the information stated on this form shall remain confidential to staff at Core Arts. I understand that as part of the remit for membership Core Arts must have up-to-date details of my principle care co-ordinator or key worker.

I agree that Core Arts will only contact my care co-ordinator at my request unless they have due concern about my well-being.

SIGNATURE\*

DATE\*