



# WARM UP COUNTIES MANUKAU APPLICATION FORM

## 1. Contact details

(Mr/Ms/Mrs/Miss) First name..... Last name.....  
 Other names..... Date of Birth.....  
 Address..... Suburb..... Postcode.....  
 Phone Home..... Work..... Mobile..... Email.....

## Housing details

**2. Do you: (please tick)**  Own your home  Rent privately  
 Your landlord's name..... Landlord's phone.....  
 Landlord's mobile..... Landlord's email.....  
**3. When was your home built?**  Prior to 1st January 2000 **Year built (approx.)**.....  Don't know

## Other details

**4. How many children live in your home?**  
 Under 2 years of age ..... Between 2 & 14 years of age ..... Babies due ..... Babies born premature (<37 weeks) .....

**5. Have any of the children aged 14 and under living in your home had any of the following conditions in the past?**  
 Asthma  Ear Infections  Bronchitis  
 Pneumonia  Bronchiolitis/Bronchiectasis  Other (please specify).....

**6. How many people aged 65+ years live in your household?** .....

**7. Has anyone living in your household aged 65+ years had any of the following conditions in the past year?**  
 Asthma  Heart Conditions  Pneumonia  
 Chronic Lung Disease (Including Emphysema, Bronchitis)  Other (please specify) .....

**8. A. Has anyone in your household been in hospital in the past year?**  Yes  No  
**B. What was the hospitalisation for?** .....

**9. Does anyone in your household have a disability or ongoing health issue?**  
 Yes (please specify) .....  No

**10. What ethnic group do you identify with?**  
 Maori (Iwi) .....  Pacific (please specify) .....  
 NZ/European  Asian  Other (please specify) .....

**11. How did you find out about this programme?**  
 Health Professional e.g. Doctor, Plunket, Hospital .....  Application received in the mail  
 Community Services  Other source (please specify).....

**12. Do you (the applicant) have a Community Services card?**  Yes  No Expiry Date: ..... /.....

**YOUR CARD DETAILS WILL BE SIGHTED AND VERIFIED BY THE INSULATION PROVIDER AT THE FIRST APPOINTMENT.**

I understand an adult needs to be home for:  A visit from the nurse  2 or 3 visits to check and fit insulation

I confirm that I am the: (please tick)  Home Owner  Tenant  Community Services card holder

Signature ..... Date .....

To support your application we recommend that you obtain a letter of support from your family doctor or health professional stating why your health and that of your family would be improved by having your home insulated.



Please return this application to The WARM UP Co-ordinator at:  
WARM UP COUNTIES MANUKAU, PRIVATE BAG 94052,  
SOUTH AUCKLAND MAIL CENTRE, AUCKLAND, 2241

Phone: 09 262 9583  
Fax: 09 262 9501

Affix 50c  
stamp here

*Please return this application to:*



**WARM UP COUNTIES MANUKAU**  
**Private Bag 94052**  
**South Auckland Mail Centre**  
**AUCKLAND 2241**

Phone: (09) 262 9583

Fax: (09) 262 9501

Email: [warmup@CMDHB.org.nz](mailto:warmup@CMDHB.org.nz)

Seal here & post