SUPPLEMENTARY WELFARE ALLOWANCE
EXCEPTIONAL HEATING NEEDS SUPPLEMENT

(S.W.A. 16 - October 2011)

To be used in conjunction with S.W.A. 1

Office Use
Date Received

By Whom

Information given will be treated as strictly confidential

PLEASE

- **Use BLOCK LETERS**
- **Complete Section 1**
- **Request and authorise your Medical Practitioner (G.P./Doctor) to complete Section 2**

Section 1 : To be completed by applicant

Name: _____ Date of Birth _____

Address: _____

_____

_____

_____

P.P.S. Number

I wish to claim an Exceptional Heating Needs Supplement.

I request and authorise my Medical Practitioner (G.P./Doctor) to complete Section 2

Signed: _____ Date: _____

Applicant

Section 2 : To be completed by your Medical Practitioner (G.P./Doctor)

NB In order to be considered for an Exceptional Heating Needs Supplement, the person named below must require an exceptional level of heating due to ill health or infirmity.

Name of Patient _____ Date of Birth _____

Medical Condition(s) _____

_____

_____

I certify that _____ has an exceptional heating need due to the medical condition outlined above. This exceptional heating need will continue for a period of _____ _____ .

Signed: _____
Medical Practitioner (G.P./Doctor)

Office Stamp

Date: _____ Telephone: _____

For Office Use Only

_____

_____

_____

_____

Signed: _____ Date: _____