COMHAIRLE CHONTAE SHLIGIGH
SLIGO COUNTY COUNCIL
HOUSING SECTION
Sligo County Council, County Hall, Riverside, Sligo Tel: 071 911 1214

ADAPTATIONS (DPG) TO LOCAL AUTHORITY HOUSES FOR OLDER PEOPLE OR PEOPLE WITH A DISABILITY (HAW)

Purpose of Grant

The scheme is available to address the needs of older people or people with a disability, who may require stair lifts, ramps, rails, level access showers and other minor works deemed necessary to facilitate the mobility needs of a member of a household.
Please note that maintenance works and energy works/upgrades are not eligible under this scheme.

Please complete the attached Application Form, all questions must be answered.

INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT

Please write your answers clearly in block capital letters

Checklist

Please ensure that the following is included before submitting application for adaptation works:

- Fully completed application form (HAW) ☐
- Completed Disability and/or Medical Information Form (HMD – Form 1) ☐
- Completed Occupational Therapist Report (If required) ☐

Note: *An occupational therapist (OT) report is required if you are applying for any of the following:*

- *An adaptation to meet a specific need*
- *A stair lift*

Please also note that the Council may request that an Occupational Therapist's Report be submitted in other instances as considered appropriate.

The scheme is subject to eligibility and availability of funding from the Department of Housing, Local Government and Heritage. It should be noted that it is a requirement that a tenant(s) has a clear rent account.

Completed applications forms should be returned to:
Jackie Dunleavy, Housing Section, Sligo County Council, County Hall, Riverside, Sligo.
Tel: 071-9111214

For official use only
HAW Ref: _____

APPLICATION FORM FOR ADAPTATIONS (DPG) TO LOCAL AUTHORITY HOUSES FOR OLDER PEOPLE OR PEOPLE WITH A DISABILITY (HAW)

Name (Tenant): (1) _____

Name (Joint Tenant): (2) _____

Address: _____

_____

Contact Phone Numbers: (1) _____ (2) _____

Email Address: (1) _____ (2) _____

Date of Birth (1) _____ (2) _____

MPRN: _____ (this number is listed on all Electricity Bills)

Gas Number: _____

Occupation: _____

Please state grounds under which you are applying for a HAW grant by ticking the relevant box below.

Works Requested:	Provision of rails	☐
	Provision of access ramps	☐
	Stair Lift	☐
	Level Access Shower	☐
	Adaptation to facilitate Wheelchair Access	☐
	Other minor works deemed necessary to facilitate the mobility needs of a member of household – to be outlined hereunder	☐

_____

_____

Please list all occupants in dwelling

Name	Sex M/F	Relationship to Tenant	Date of Birth	PPSN

DECLARATION

I/We the undersigned declare that the foregoing information is correct and wish to apply to Sligo County Council for Housing Adaptation Works to be carried out on our dwelling. I/We the undersigned declare that the above-named household members are normally resident at this address listed above. I/We the undersigned authorise Sligo County Council to make whatever enquiries it considers necessary to verify details.

Signature of Tenant: _____

Date: _____

Print Name: _____

Signature of Joint Tenant: _____

Date: _____

Print Name: _____

SLIGO COUNTY COUNCIL

HMD–Form 1

Disability and/or Medical Information Form

About this form

This form is for anyone who is applying for social housing or a social housing transfer **due to a disability or medical grounds.** The information provided will be used to assess if priority status should be awarded to an application.

What is priority status and who we give it to

When we give a person priority status on disability or medical grounds, this means they go **nearer to the top of the waiting list,** as set out in the Local Authority's Allocation Scheme.

Priority status may be awarded if the following three criteria apply to your household:

- you or someone in your household has a disability or a medical condition and
- the current accommodation is not suitable to meet the needs of the person with a disability or medical condition and
- a change in housing will improve or stabilise the circumstances of the person with a disability or medical condition.

Who needs to fill out and sign each section of this form

Section 1 and 2 to be filled out and signed by the person with a disability or medical condition or by the applicant for social housing support if the person with a disability or medical condition is a dependant of the applicant.

Section 3 and 4 to be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Other information

A Healthcare Professional includes the following professions: Consultant, General Practitioner (GP), Mental Health Nurse, Public Health Nurse, Occupational Therapist and Social Worker. If you are considering using a Healthcare Professional not listed above, please contact your Local Authority to confirm if this is acceptable.

An Occupational Therapist report **must be provided** where there is a need for a specific accommodation requirement.

If you require extra space to complete the form please include additional pages.

Section 1: Disability and/or Medical Information

This section must be filled out by the applicant.

Please tick (✓) the box to show the category you are applying under.

Disability grounds ☐ Medical grounds ☐

Please state your disability and/or medical condition

If you are a person with a disability, please tick (✓) which category of disability applies to you.

Physical ☐ Mental Health ☐ Intellectual ☐ Sensory ☐

Section 2: Personal Details

This section must be filled out as outlined on page 1. Please make sure the details you fill out here are the same as on your Social Housing Application Form.

Please fill in the details of the main housing applicant below.

First name

Surname

PPS number

Date of Birth

Declaration

I permit the Healthcare Professionals in Section 3 to give relevant medical details to the Local Authority to identify my housing needs.

Signature

Date

If the person with a disability or medical condition is not the main housing applicant, please fill in their details below.

First name

Surname

PPS number

Date of Birth

Section 3A: Medical Reference

This section must be filled out by two Healthcare Professionals (see page 1) who work with the person with a disability or medical condition.

Details of Healthcare Professionals completing this form

Healthcare Professional 1

First name

Surname

Name of organisation

Telephone

Email

Please indicate the professional service you provide to the person with a disability or medical condition.

Please tell us the total length of time the person with a disability or medical condition has been receiving your service.

One consultation only ☐ Weeks (number) ☐ Months (number) ☐ Years (number) ☐

Healthcare Professional 2

First name

Surname

Name of organisation

Telephone

Email

Please indicate the professional service you provide to the person with a disability or medical condition.

Please tell us the total length of time the person with a disability or medical condition has been receiving your service.

One consultation only ☐ Weeks (number) ☐ Months (number) ☐ Years (number) ☐

Section 3B: Applicant's Current Accommodation

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Is the person with a disability or medical conditions current accommodation directly or negatively affecting their disability or medical condition? If the answer is yes, please explain below.

Healthcare Professional 1

Healthcare Professional 2

Section 3C: Accommodation Need of Applicant

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

How would a change in location of accommodation benefit the person with a disability or medical condition?

Healthcare Professional 1

Healthcare Professional 2

What change in the type of accommodation would benefit the person with a disability or medical condition? and how?

Healthcare Professional 1

Healthcare Professional 2

What change in the design of accommodation would benefit the person with a disability or medical condition? and how?

Healthcare Professional 1

Healthcare Professional 2

Section 3D: Support Needs for the Applicant

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Are supports currently needed to enable the person with a disability or medical condition to live independently? Please provide details.

Healthcare Professional 1 Yes ☐ No ☐

Healthcare Professional 2 Yes ☐ No ☐

Will the person with a disability or medical condition need any additional or new supports? Please provide details.

Healthcare Professional 1 Yes ☐ No ☐

Healthcare Professional 2 Yes ☐ No ☐

Section 4: Healthcare Professional Declaration

Healthcare Professional 1

I declare that the information and details I have provided on this form are correct and true.

I agree to the Local Authority contacting me, if necessary, to verify the details I have provided.

Signature	Date

Healthcare Professional 2

I declare that the information and details I have provided on this form are correct and true.

I agree to the Local Authority contacting me, if necessary, to verify the details I have provided.

Signature	Date

If you require extra space to complete the form please include additional pages.