HOUSING ADAPTATION GRANT FORM

LOCAL AUTHORITY HOUSING

- Please read the attached conditions prior to completing this Application Form
- All questions must be answered and please write your answers clearly in block capital letters

Completed applications forms should be returned to:

Galway County Council

Housing Maintenance,

Áras an Chontae

Prospect Hill

Galway

091 509306

Applicant: _____

Address:

_____

_____

_____

_____

Telephone No: _____ **Mobile No:** _____

Date of Birth: _____ **P.P.S. No:** _____

Occupation _____

Name of person for whom grant aid is sought *(if different from Applicant):*

_____

Relationship to applicant: _____

Please state if renting property from Galway County Council: _____

Rent/Customer I.D: _____

Is the person with the disability residing at the address above: _____

How long has he/she been living at this address: _____

Name and address of General Practitioner: _____

_____

_____

(Please note that the attached doctor's certificate HGD2 must be completed by your G.P. and returned with this application form)**Details of all persons living in property for which grant aid is sought *(including applicant and/or person with a disability)***

Name	Relationship to applicant	Date of birth

Number and description of rooms in the dwelling:

	Bedrooms	Living	Dining	Kitchen	Other
Upstairs					
Downstairs					

General description of proposed works:

_____

_____

_____

_____

Has a Disabled Persons Grant or a Housing Adaptation Grant been paid previously in respect of the same premises or person? If yes, please give details:

_____

_____

Signature of Applicant: _____ Date: _____

HGD2

CERTIFICATE OF DOCTOR

Please note that this form must be fully completed on behalf of your patient in order to accurately assess his/her eligibility. If the Council considers it necessary the application may also be assessed by an Occupational Therapist. The medical information provided will be treated in the strictest confidence.

1. I HAVE EXAMINED

_____

AND CERTIFY THAT HE/SHE IS DIAGNOSED AS SUFFERING FROM

_____

_____

_____

2. I CERTIFY IN MY OPINION THAT THE ABOVE NAMED HAS:

(A) AN ENDURING DISABILITY _____

(B) A SEVERE LEARNING DISABLILTY _____

(C) IS ENDURING SEVERE MENTAL _____

ILLNESS AND IS UNDERGOING TREATMENT

FOR SAME

(D) OTHER (PLEASE SPECIFY)

_____

3. PLEASE CERTIFY THE CONDITION OF THE APPLICANT BASED ON THE FOLLOWING PRIORITIES. (Please tick appropriate box)

PRIORITY 1 ☐ **Terminally ill, or mainly dependent on family, or a carer or where alterations/adaptations would facilitate the discharge from hospital or alleviate hospitalisation in the future.**

PRIORITY 2 ☐ **Mobile, but needs assistance in accessing facilities, or where, without the adaptation the disabled persons' ability to function independently would be hindered.**

PRIORITY 3 ☐ **The applicant is independent, but requires special facilities to improve their quality of life, e.g. separate bedroom or living space.**

4. YOUR PATIENT SINCE: DAY MONTH YEAR

5. DATE CONDITION COMMENCED: DAY MONTH YEAR

HOW LONG DO YOU EXPECT THIS CONDITION TO CONTINUE: _____

WOULD YOU CONSIDER THE DISABILITY TO BE PROGRESSIVE: YES ☐ NO ☐

HOW DOES THE DISABILITY IMPACT ON APPLICANT'S LIFE:

_____
_____
_____
_____
_____

PLEASE INDICATE THE DEGREE TO WHICH THE APPLICANT'S DISABILITY HAS AFFECTED HIS/HER MOBILITY.

IS THE APPLICANT:

☐ **FULLY DEPENDENT** ☐ **INDEPENDENT WITH HELP** ☐ **INDEPENDENT**

<u>MOBILITY: (Please tick where appropriate)</u>

☐ **1. WHEELCHAIR USER**
☐ **2. IS APPLICANT MEDICALLY CAPABLE OF OPERATING A STAIRLIFT SAFELY**
☐ **3. UNABLE TO CLIMB STAIRS**
☐ **4. UNABLE TO GO OUTSIDE UNAIDED**
☐ **5. ONLY ABLE TO WALK USING A WALKING AID**
☐ **6. PAINFUL MOBILITY**
☐ **7. CONFINED TO BED**

OTHER PLEASE SPECIFY _____

<u>SIGHT: (Please tick where appropriate)</u>

(A) Blind ☐ **(D) No defect** ☐

(B) Sight corrected with glasses ☐ **(E) Other – Please specify** ☐

(C) Partially sighted ☐

5. THE APPLICANT HAS APPLIED FOR THE FOLLOWING ADAPTATIONS/MODIFICATIONS TO HIS/HER HOME:

_____

_____

_____

6. DO YOU CONSIDER THAT ALL/SOME OF THESE ADAPTATIONS/MODIFICATIONS ARE NECESSARY:

_____

_____

_____

7. WHY DO YOU CONSIDER THAT THE WORKS PROPOSED BY YOU ARE NECESSARY:

_____

_____

_____

8. ANY OTHER COMMENTS OR ADDITIONAL INFORMATION:

Is your patient attending a Consultant/Specialist in relation to their medical condition?

Yes ☐ No ☐

If **yes,** a letter from the Consultant/Specialist is required outlining details of the patient's medical condition(s). In circumstances where such a letter cannot be provided, the Council will accept a report from a suitably qualified person (including the GP) outlining the Consultant's/Specialist's medical prognosis/commentary on the case and how the applicant's housing conditions impact on their health.

Note: In providing this information it is important that as much details as possible in relation to the medical condition is given including the stage/severity of the illness and whether the condition is degenerative. This information will assist the Council to prioritise cases as the

level of demand is greater than the available resources and it is important that those most in need are assisted by way of grant funding.

Is your patient attending an Occupational Therapist?

Yes ☐ No ☐

If yes, please provide OT Report.

9. NAME OF DOCTOR: _____

DOCTOR'S STAMP

ADDRESS: _____

_____

SIGNED: _____

DATE: _____

Conditions of Scheme

1. *Purpose of Grant*

The Housing Adaptation Grant for People with a Disability is available to assist in the carrying out of works which are reasonably necessary for the purposes of rendering a house more suitable for the accommodation of a person with a disability who has an enduring physical, sensory, mental health or intellectual impairment. The types of works allowable under the scheme include the provision of access ramps, downstairs toilet facilities, stair-lifts, accessible showers, adaptations to facilitate wheelchair access, extensions, and any other works which are reasonably necessary for the purposes of rendering a house more suitable for the accommodation of a person with a disability.

Types of works allowable under the scheme:
Level deck shower
Handrails
Ramps
Convert existing room to bathroom
Stair lift/Hoist – **OT Report Required from applicant**
Ancillary & Necessary Works Approved by Engineer

2. *Appeals Procedure*

In processing applications under the Housing Adaptation Grant for People with a Disability, the authority recognises that some applicants may be dissatisfied with the authority's decision. The authority will give every applicant an appeal mechanism, which will allow him or her to have the decision in his or her case reconsidered by another official.

The following procedure shall apply to each appeal:

Applicants are invited to submit a written appeal on any decision notified to them by the local authority on their application within 3 weeks of the date of the decision stating the reasons for the appeal. The appeal will be considered and adjudicated upon within 4 weeks of receipt. A decision on an appeal will be notified to each applicant within 2 weeks of the decision being made.

3. *Checklist*

Please ensure that the following documentation is included in the application for grant aid:

☐ Fully completed application form (HGD1);

☐ Completed G.P. Medical report (HGD2);

If you require assistance in filling out this form please contact Housing Maintenance