Doorway to Life (Abode)

Kilbrack Grove, Skehard Road, Blackrock, Cork.
Telephone 021 4916180

ACCOMMODATION APPLICATION FORM

INCOMPLETE APPLICATION AND CONSENT FORMS CANNOT BE PROCESSED. PLEASE USE BLOCK CAPTALS

Abode is not a medical / nursing facility and therefore is not in a position to provide active medical or nursing care.

COMPLETED FORMS SHOULD BE RETURNED TO THE SERVICE MANAGER, AT THE ABOVE ADDRESS

General Information

Do we need to provide information about your application, or a copy of this form in a format other than standard print? **Yes __ No __**
If yes, in what format do you require the information ? e.g. large print, computer disk, tape. Please let us know.
Do we need to make any particular arrangements if we contact you, for example, because of a visual or hearing impairment ? **Yes__ No __**
If yes, what arrangements do we need to make? Please let us know.

Date of Application	

Personal Details

Surname		
First Name		
Date of Birth		
Address		
Contact Numbers	Home	Mobile

Other who may be housed with applicant				
Title	**First Name**	**Surname**	**Date of Birth**	**Gender M/F**

Marital Status of Applicant (please tick)		
Single	Married	Widowed
Cohabiting	Divorced	Separated

Nature of Tenure of Existing Housing (please tick one)		
Rented		
Private	Local Authority	Housing Association
Owner Occupier		
With Mortgage	Without Mortgage	
Living With		
Family	Friends	
Living In		
Bed and Breakfast	Nursing Home	
Hospital	Residential Care Home	
Other (please specify)		

Please give details of current / previous landlords			
Address of Property	**Landlords Name and Address**	**Period of Tenancy Date from**	**Period of Tenancy Date to**

Are you on a local authority housing waiting list? YES / NO
If Yes please confirm which authority and length of time on waiting list

Property Condition
Please indicate if you consider your current accommodation to be in a poor state of repair, provide details below.
Accommodation Difficulties
Please indicate if you consider your current accommodation to be lacking services such as electricity, wholesome water and heating, provide details below.

Do you have difficulties managing any aspects of the following in your current accommodation?

	No Difficulty	Some Difficulty	Extreme Difficulty
External Access (paths, steps, doors)			
Internal Access (doors, corridors, stairs)			
Bedroom (access and transfer in/out of bed)			
Living Room (access and circulation space)			
Bath / shower (access and use of facilities)			
Toilet (access and transfer to and from)			
Kitchen (access and use of equipment)			

Comments

Personal Circumstances

Security / Anti Social Behaviour / Personal Safety
Please indicate below any security or anti social behaviour problems you encounter in your home or in your neighbourhood including the frequency of the problem.

Social Contact
Please indicate below if you consider your opportunities for social contact or personal autonomy are limited by your current housing circumstances.

Support
Please indicate below if the move to new accommodation will allow you to receive additional support. You should indicate the nature of support that is likely to be provided and who it is to be provided by. Where an applicant is offered accommodation on the basis that they will continue to receive services that they are currently availing of this continuation of services in their new home must be confirmed in writing to Abode by the provider of those services.

Carer Circumstances
Should you be receiving informal care from a family member or friend please indicate if your carer is having any difficulties in providing this assistance.

Travel / Isolation
Do you feel isolated sometimes, or perhaps have to travel significant distances to access education, training, medical services etc, if you do please provide details below.

Please use this section to add any additional comments you may wish to make.

SUPPORT TIMETABLE

Please detail **all** help and services regularly received during the week. If there is no help please write **None** here __________.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
GETTING UP							
BREAKFAST							
MORNING							
LUNCH							
AFTERNOON							
TEA							
EVENING							
SETTLE							
OVERNIGHT							

Comments

Service Providers

Please identify all those organisations and professionals that currently provide you with a service, e.g. personal assistant, home help, occupational therapist, community nurse, voluntary service group etc.

Name	Job Title	Tel No
Address		
Name	**Job Title**	**Tel No**
Address		
Name	**Job Title**	**Tel No**
Address		
Name	**Job Title**	**Tel No**
Address		

Declaration and Consent

I / we declare that the information and particulars given by me / us on this application form are true and correct and I / we undertake to provide immediate notification of any change of circumstances.

I / we provide our authorisation for the making of enquiries relevant to this application and the verification of the information given. I understand this may mean the contacting of previous landlords, health care professionals, service providers etc who I have referred to on the form.

I / we understand that the providing of false or misleading information may prejudice this and future housing applications.

Signature ______________________ **Date** ________________

Signature ______________________ **Date** ________________

STATEMENT OF CONSENT TO SHARE INFORMATION

NAME
DATE OF BIRTH

Please read this carefully, complete the restriction box if appropriate and then sign, and date the form. If you have any concerns please discuss them with a member of staff.

I **agree** that the information provided in my application may be shared with Abode staff, and other service providers who may contribute to my care and support. I understand that other agencies may be asked for information about me.

I **understand** that this information will be used for the purpose of providing the most appropriate services, or supports to me.

I also **understand** that agencies may use anonymised information for statistical purposes and that the law may allow in some circumstances for other agencies to be provided with information about me.

I **understand** that I may withdraw my consent to share information at any time and this may result in a review of the services being available.

I **understand** that my information will be held securely on paper and on computer in accordance with the Data Protection Acts.

I understand that I have the right to restrict what information may be shared and with whom. **I make the following restrictions to sharing of information about me:** (if applicable)	
Signature	**Print Name**
Date	

In order to alter your consent, please contact the staff member you have most contact with.

MEDICAL REPORT

(to be completed by applicant's Doctor)

Applicants Name	
Doctors Details	
Name	
Address	
Phone	
E-Mail	
Applicant's Medical or Drug Payments Card Number	
Doctor's Registered Number on card	
Date of most recent hospital stay.	
Medical History / Diagnosis	
Current medications (including time and administration route for each)	
Has the applicant any other underlying conditions? (epilepsy, a heart condition, asthma, pressure sores, ulcers etc.) Please give a brief outline and list any medication used.	
Please advise of any open wounds and confirm appropriate dressings.	

Has the applicant a history of psychiatric illness or challenging behaviour?
Is the applicant allergic to any medications?
Is the applicant allergic to any foods?
Does the applicant require a special diet or have specific dietary needs eg, drinks with a straw, uses thickener in liquid, difficulty swallowing etc?
Does the applicant require assistance or supervision in taking medication?
Please advise if the applicant has ever had or been in contact with any of the following. Hepatitis B or C MRSA HIV Glandular Fever Any other infectious or contagious disease.

Please detail any special appliances used by the applicant, e.g. conveens, catheters, drainage bags etc., together with required sanitary / continence products.

Any other comments or observations?

DOCTORS SIGNATURE **DATE**
DOCTORS STAMP