SOUTH DUBLIN COUNTY COUNCIL

APPLICATION FOR ALTERATIONS ON MEDICAL GROUNDS FOR COUNCIL TENANTS UNDER THE DISABLED PERSONS GRANT SCHEME.

Name of Tenant: ________________________________

Address: ________________________________ **Phone/ Contact No:** __________________

Name of Person Seeking Grant: __________________________________

Relationship to Tenant: __________________________________

PPS NO: ________________ **Date of Birth:** _______________

Date of Tenancy __________________ **Rent Acc. No** ___________________

Please state the name and address of the Occupational Therapist

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PLEASE NOTE:

APPLICANTS MUST PROVIDE A FULL OCCUPATIONAL THERAPY REPORT TO INCLUDE RECOMMENDATIONS AND SPECIFICATIONS FOR THE WORKS REQUIRED. FAILURE TO DO SO WILL RESULT IN AN APPLICATION NOT BEING PROCESSED.

IT SHOULD BE NOTED THAT A CLEAR RENT ACCOUNT IS REQUIRED FOR ALL APPLICATIONS.

Have you applied previously for works to be carried out under the Disabled Persons Grant Scheme?

Yes ☐ **No** ☐

If so, please give details.

____

Have you applied to transfer to alternative accommodation? **Yes** ☐ **No** ☐

Have you applied to purchase your house? **Yes** ☐ **No** ☐

If it is not possible to carry out required works to your dwelling, Would you consider a transfer to alternative suitable accommodation?

Yes ☐ **No** ☐

Details of all persons residing in house

Name	Date of Birth	Name	Date of Birth

House type - please tick appropriate box:

Single Storey ☐ Mid Terraced ☐ No of Bedrooms ☐ Duplex ☐

Two Storey ☐ End Terrace ☐ No of Bathrooms ☐ Other ___________

* Please specify if bedroom/bathroom/toilet facilities on ground floor: Yes ☐ No ☐

* Please specify if there are shower facilities in situ? ______________________

Staircase: Straight ☐ Curved ☐

Right or left hand side ascending as viewed from hall door ______________________

Please state adaptations required and the reasons for same.

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I AUTHORISE SOUTH DUBLIN COUNTY COUNCIL TO CONTACT ANY HEALTHCARE WORKER (FOR EXAMPLE, GENERAL PRACTITIONER, HOSPITAL CONSULTANT, SOCIAL WORKER, CARE WORKER, OCCUPATIONAL THERAPIST ETC.) IN RELATION TO THIS APPLICATION.

I acknowledge and accept that in the event of my wishing to **Purchase this House**, the net cost of the work updated, in accordance with the terms of the Sales Scheme current at the time will be added to the cost of the house itself.

In the event of a change in circumstances the decision to remove any alterations carried out in respect of disability works will be at the discretion of South Dublin County Council.

Signature of applicant: ______________________ **Date**: __________________

Doctors certificate for completion

Name, Address and Age of Disabled person

DOB **AGE**

The alterations are necessary because (Please give details of prognosis of the nature and extent of the disability with particular reference to mobility of the applicant and his/her future prognosis

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____

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Please indicate the appropriate category for the above named applicant based on the following criteria

Priority level 1-High level of need **Please tick box**

Disabled person at risk unless alterations are carried out.
Alterations would facilitate discharge from hospital and/or alleviate the need for hospitalisation in the future.
Applicants with terminal illness or presenting with a rapid progression of a degenerative condition.

☐

Priority level 2-Moderate level of need

Without the alterations the disabled persons ability to function independently would be severely hindered.

☐

Priority level 3-Reduced level of need

The alterations would enhance the disabled persons quality of life/living conditions.

☐

I recommend that the following alterations be carried out to the applicant's home:

____

____

____

As an alternative the following alterations would benefit the applicant:

____

Doctor's name: ____

Doctor's address: ____

Signed: ___________________________ **Date:** ___________________________

Telephone No: ______________________ **Fax No:** _________________________

Doctor's Stamp

Please note that application is invalid unless stamped by Registered Doctor/

Proposed Work. Note: Proposed works must be certified on foot of Doctor's certificate.

- This form is to be used by Tenants of South Dublin County Council applying for works to be carried out on disability grounds.
- Please complete the form fully. Incomplete forms will be returned.
- Please sign the application form in the appropriate place.
- Please ensure the Doctor's Certificate is completed and stamped.
- The Address to return your completed application to is:

South Dublin County Council
Medical Section
Housing Department
County Hall
Town Centre
Tallaght
Dublin 24.

Tel: 01-4149000
Fax: 01-4149028

South Dublin County Council
Medical Section
Housing Department
County Hall
Town Centre
Tallaght
Dublin 24.

For Official Use
Med File No…………….
Date Rec…………………

Phone 01 - 4149000 **Fax 01 - 4149028**

South Dublin County Council has received an application for works under the Disabled Persons Grant Scheme from:

NAME……………………………………ADDRESS……………………………………………

This application will be referred for consideration and you will be advised of the outcome.