DONEGAL COUNTY COUNCIL

HOUSING GRANTS FOR PERSONS WITH DISABILITY.

APPLICATION FORM FOR
Mobility Aids Grant Scheme
and
Housing Adaptation Grant Scheme.

Please read the attached conditions prior to completing this form

All questions must be answered

Please write your answers clearly in block capital letters

Works must not commence prior to receipt by the Local Authority of the grant application and written approval from the Local Authority

The person for whom the grant is sought must occupy the house as his/her normal place of residence

APPLICANT DETAILS

Applicant Name _____

Applicant Address: _____

_____ **Eircode:** _____

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

P.P.S. No: _____ **Email Address:** _____

PERSON REQUIRING GRANT ASSISTANCE *(if different from Applicant).*

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

_____

Relationship to applicant: _____

Is the person with the mobility problems residing at the address above: _____

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

HOUSEHOLD/PROPERTY DETAILS:

Name of owner of the property to which the proposed adaptation works are to be carried out:

_____

Number and description of rooms in the dwelling:

	Bedrooms	**Living**	**Dining**	**Kitchen**	**Bathroom**	**Other**
Upstairs						
Downstairs						

Details of all persons living in property for which grant aid is sought

Name	Relationship to applicant	Date of Birth	Gross Income (previous tax year)	Occupation * *(if applicable)*

(including applicant and/or person with mobility problems)

Gross Annual Household Income from all sources: €_____
(please refer to explanatory note under conditions of scheme)

***Evidence must be submitted from Educational / Training body for household members aged between 18 and 23 years and in full time education or engaged in a FAS apprenticeships.**

OTHER DETAILS / QUESTIONS

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

_____

_____

Have you paid your Local Property Tax? _____
(PLEASE ENCLOSE EVIDENCE)

If the house has been provided by the Council, please state whether

Rented ☐ **or Purchased** ☐

Are there any monies due to the Council by the owner/tenant of the dwelling in respect of any of the following (if so, please furnish account no. and amount due)?

i) Rent/purchase repayments - Yes/No A/c No. _____ Amount € _____

ii) Other (please specify e.g. Housing Loan A/c etc.)
Yes/No A/c No. _____ Amount € _____

GENERAL PRACTITIONER DETAILS

Name and address of General Practitioner: _____

_____

(Please note that the attached doctors certificate must be completed by your G.P. and returned with this application form)

DECLARATION:

I have read the guidelines and understand the purpose of this grant, and undertake to abide by the terms of the scheme.

I understand that Donegal County Council will require information and reports from other agencies such as the HSE and I grant consent to both the Council and such other agencies to share information to enable a decision to be taken in relation to this application.

I consent to Donegal County Council reserving the right to carry out any inspection/investigations it deems appropriate (or to arrange same via the HSE or other party) in the context of the consideration of the application. I acknowledge that in order to make a fully informed decision on this application that the inspection process will require access to the whole dwelling.

I will not commence works prior to final written grant approval and will complete works as approved.

The person for whom the grant is sought occupies the house as his/her normal place of residence.

I declare that the foregoing particulars are correct and that the gross annual household income figure quoted is the household's only source of income.

Signature of Applicant: _____ Date: _____

MINOR WORKS

If you deem that minor works may meet your needs, the assessment can be carried out more quickly. 'Minor works' in this regard refer to: the provision of access ramps, railings & pathways, and / or minor bathroom adaptations to provide level access shower facilities. If you only require minor works, please complete **FORM A** and arrange for your Doctor to certify.

MAJOR WORKS

If you are applying for more 'major works' such as an extension, major internal adaptation works or a stair lift, please complete **FORM B** and arrange for your Doctor to certify.

FOR OFFICIAL USE ONLY. Tick as appropriate:

☐ **Housing Adaptation Grant.**

OR

☐ **Mobility Aids Grant.**

FORM A
APPLICATION FOR MINOR WORKS.

(Please note that if you only require Minor Works as outlined below, your application can be processed more quickly).

NATURE OF WORKS REQUESTED BY APPLICANT (Tick Box as appropriate).

Access ramps, railings, pathway. ☐

Minor bathroom adaptation to provide level access shower ☐

Other minor works to facilitate the mobility needs of the person. ☐

APPLICANT'S SIGNATURE: _____ DATE: _____

CERTIFICATE OF DOCTOR

Patient Name & Address:_____

_____ DOB: _____

I hereby certify that the above named person suffers from: (PRINT IN BLOCK CAPITALS PLEASE)

_____

_____

I also hereby certify that the above named person:

- has a **permanent and substantial mobility difficulty**, and
- **the works requested on the attached application form are essential for him/her to maintain or increase his/her functional independence within their home**.

DOCTOR'S NAME / ADDRESS

_____

_____

_____

DOCTORS STAMP

DOCTORS SIGNATURE: _____ DATE: _____

****PLEASE ENSURE CERTIFICATE IS SIGNED & STAMPED BY DOCTOR**

FORM B

(Only required if Major Works are sought)
i.e. extension, major adaptation works or stair lift.

CERTIFICATE OF DOCTOR

NAME AND ADDRESS OF PATIENT: _____

_____ DOB: _____

I hereby certify that the above named person suffers from: (PLEASE SELECT AS APPROPRIATE)

Progressive Neurological Conditions:

- ☐ Multiple Sclerosis
- ☐ Motor Neuron Disease
- ☐ Parkinson's Disease
- ☐ Progressive Terminal Illness / Cancer
- ☐ Alzheimer's / Dementia
- ☐ Amyloidosis
- ☐ Muscular Dystrophy
- ☐ Fredericks Ataxia
- ☐ Huntington's Chorea

Acquired Brain Injury:

- ☐ Brain Injury
- ☐ Alcohol Related Brain Injury
- ☐ Stroke

Other High Level Care Need Groups:

- ☐ Wheelchair dependant
- ☐ Dependant on specialised equipment to manage in the home such as hoists
- ☐ Dependant on high level of care support being provided in the home (generally more than one carer assigned)
- ☐ Spinal cord injuries such as quadriplegia or paraplegia

Details of any other conditions:
((PRINT IN BLOCK CAPITALS PLEASE)

_____

_____

DOCTOR'S NAME / ADDRESS

_____

_____

DOCTORS STAMP

DOCTORS SIGNATURE: _____ DATE: _____

****PLEASE ENSURE CERTIFICATE IS SIGNED & STAMPED BY DOCTOR**

Applicants Checklist

With a view to avoiding delays, please re-check your application before submitting it to the Council using the following checklist as a guide. This will be of benefit in having your application processed.

▪ Conditions of Scheme

- ✓ I have read and understand the conditions of the scheme ☐
- ✓ I believe my application meets the condition of the scheme ☐

▪ Application Form

- ✓ All questions on the form have been fully completed ☐
- ✓ I have quoted my PPS Number ☐
- ✓ I have signed the form ☐
- ✓ The relevant Doctors Certificate (i.e. Form A OR Form B) has been completed and signed / stamped ☐

▪ Supporting Documentation

- ✓ I have enclosed evidence of household income from all sources ☐
- ✓ I have enclosed evidence of ownership of the property where applicable ☐
- ✓ I have enclosed evidence of compliance with the local property tax ☐

NB: AN APPLICATION CANNOT BE PROCESSED UNTIL ALL THE FORMS AND SUPPORTING DOCUMENTATION ARE SUBMITTED TO THE COUNCIL.