

# APPLICATION FOR TENANCY

35 Langstone Way, Bittacy Hill,  
Mill Hill East, London, NW7 1GT

**DATE SENT** \_\_\_\_\_ **DATE RETURNED** \_\_\_\_\_

**Tel: 020 8371 6611**  
**Fax: 020 8371 4225**  
**Email: [info@jbd.org](mailto:info@jbd.org)**  
**Reg. Charity No. 259480**

Name

Date of Birth  Marital Status

Permanent Address

Phone Number

**If applying for joint accommodation:**

Name of 2nd Applicant

Date of Birth  Relationship to 1st Applicant

**Present Address if different from above:**

Present Address

Phone Number

If you were born outside the UK - How long have you lived here

Is your Accommodation: Owned  Rented  Sublet  Tick where appropriate

Landlord's Name &

**If you live in a flat, house or maisonette:**

Which Floor  Is there a lift

How many: Bedrooms  Living rooms  Kitchens  Bathrooms  WC

Rent/Mortgage Payments  Do you Have Central Heating **YES / NO**

Do you or your partner have any criminal convictions? **YES / NO**

Please give details and date of conviction.

Do you live alone                      **YES / NO**

**If you do not live alone please state with whom you live and their relationship to you:**

Do you have children                      **YES / NO**                      Number of Children

**Please give the name, address and phone number for ALL of your children: (Please use a separate sheet if you have more than 2 children)**

NAME:	
ADDRESS:	POSTCODE:
TEL NO:	
HOME	
WORK	
MOBILE	

NAME:	
ADDRESS:	POSTCODE:
TEL NO:	
HOME	
WORK	
MOBILE	

**Please give the name, address and phone number for your Next of Kin and relationship:**

**Please give the name, address and phone number for your Doctor:**

**Please give details of your Synagogue membership or Burial scheme:**

**Please give your reasons for needing re-housing, including any medical or social reasons:**

**Please list your disabilities and if they are deteriorating:**

Are you registered as disabled? If yes, please give your registration number.

**YES / NO**

Are you registered blind or partially sighted?

**YES / NO**

**Independent living skills**

Are you able to undertake the following task without assistance?

Bath/ shower

**YES / NO**

Shopping

**YES / NO**

Cooking

**YES / NO**

Cleaning

**YES / NO**

**What, if any, domiciliary services and personal care (meals on wheels, home help, district nurse etc) do you receive and how often:**

What is your National Insurance No.

**Do you receive any of the following Benefits?**

Income Support	<b>YES / NO</b>	How much per week	<input type="text"/>
Housing Benefit	<b>YES / NO</b>	How much per week	<input type="text"/>
Attendance Allowance	<b>YES / NO</b>	How much per week	<input type="text"/>
State Pension	<b>YES / NO</b>	How much per week	<input type="text"/>
Private Pension	<b>YES / NO</b>	How much per week	<input type="text"/>
Other disability allowance	<b>YES / NO</b>	How much per week	<input type="text"/>
Additional Income	<b>YES / NO</b>	How much per week	<input type="text"/>

**Please give details of any Capital**

Cash	<input type="text"/>	Bank/Building Societies	<input type="text"/>
Policies	<input type="text"/>	Shares/ Investments	<input type="text"/>
Other Assets	<input type="text"/>		

Do you handle your own finances? **YES / NO**

**If the answer is no, please provide below the name and address of the person that manages your finances on your behalf:**

Do you have a Power of Attorney? **YES / NO**

**Please give details:**

Have you applied to anyone else for re-housing? **YES / NO**

**Please list local authorities and Housing Associations you have applied to for re-housing:**

**Area required**

<b>North East</b>		<b>North West</b>	
Ilford	<input type="checkbox"/>	Wembley	<input type="checkbox"/>
Wanstead	<input type="checkbox"/>	Kingsbury	<input type="checkbox"/>
South Woodford	<input type="checkbox"/>	Mill Hill East	<input type="checkbox"/>
		East Finchley	<input type="checkbox"/>

**Have you applied to Jewish Blind & Disabled before? If so, when?**

**Any further comments:**

**Please note that in the event of a tenancy being offered and taken up, where it is discovered that a tenant has deliberately given false information in their application for a tenancy, a County Court can make an order for possession of the dwelling on behalf of the Landlord under schedule 2 of the Housing Act 1985 and no alternative accommodation need be provided.**

**In order for your application to be considered, a medical questionnaire is required to be completed for each applicant by your doctor(s). We regret that we are not able to pay any fee which your doctor(s) might charge**

***The information contained on this form and in the attached medical questionnaire could be required for calculation of Housing Benefit or Supporting People benefits and I/we agree for this information to be made available to the relevant Local Authority or Government departments.***

**Signed**

**Date**

# Tenancy Application Medical Report

(TO BE COMPLETED BY THE DOCTOR)



35 Langstone Way, Bittacy Hill,  
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Tel: **020 8371 6611**  
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Email: info@jbd.org

Reg. Charity No. 259480

Name of Applicant

Date of Birth

Address

**Is the applicant registered or registerable as physically disabled? YES / NO**

Please give details of disability and limitations they impose (including Parkinson's)

**Is the applicant registered or registerable as visually impaired? YES / NO**

Please give details and limitations this imposes

**Is there any mental disability (including confusion) YES / NO**

Please give details

**Is he/she known to have required psychiatric treatment? YES / NO**

If **YES**, please give contact details of consultant and date of treatment

**Is he/she subject to fits? YES / NO**

Please give details

**Is their disability chronic or deteriorating?**

Please give details

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**Does he/she require any form of personal or nursing care?** **YES / NO**

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Please give details

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Can he/she cook **YES / NO**

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Can he/she wash and dress self **YES / NO**

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Can he/she feed self **YES / NO**

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Can he/she walk unaided **YES / NO**

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Can he/she go up and down stairs **YES / NO**

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Can he/she get into a bath **YES / NO**

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Are any of the following used by applicant

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Walking stick **YES / NO**

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Zimmer frame **YES / NO**

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Wheelchair **YES / NO**

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Bath seat **YES / NO**

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**Has he/she been an in-patient at a hospital** **YES / NO**

Why:

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When:

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Where:

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**Please attach a list of the patients medication and treatments or detail this information**

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**Please add any points not covered in the above**

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**In your opinion will the applicant be able to live independently within a sheltered environment for the next 5 years** **YES / NO**

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**Please imprint your Stamp below:**

**Signed:**

**Dated:**