

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

Tel: 020 8371 6611 X620  
Email: [ila@jbd.org](mailto:ila@jbd.org)  
Reg. Charity No. 259480



# APPLICATION FORM FOR INDEPENDENT LIVING ADVISORY: SOLE APPLICANT

## Data Protection

We take our obligations to data protection very seriously. The personal data you share with us will be handled strictly in accordance with our policy and UK data protection law. If you would like further details about this, please ask a member of our team

Details of our Privacy Policy can be found on our website [www.jbd.org](http://www.jbd.org)

|   |        |          |
|---|--------|----------|
| Who is completing this form (please circle) | Myself | Referrer |
|---|--------|----------|

## Referrer Details (if applicable)

| Name | Relationship or Referring organisation (Eg. social worker, relative, friend) | Phone number and email address |
|------|--|--------------------------------|
|      |  |                                |

|  |                |              |       |
|--|----------------|--------------|-------|
| Please let us know applicant's preferred method(s) of communication (please circle): | Landline Phone | Mobile Phone | Email |
|--|----------------|--------------|-------|

|                            |                          |                      |   |
|----------------------------|--------------------------|----------------------|---|
| Applicant (please circle): | I am physically disabled | I am vision impaired | I am both physically disabled and vision impaired |
|----------------------------|--------------------------|----------------------|---|

If the applicant is both physically disabled and vision impaired, which has more impact on your life?

## Applicant Details

|  |     |               |          |
|--|-----|---------------|----------|
| Title (Mr, Mrs, Miss, other)   |     | Date of Birth |          |
| First name   |     |               |          |
| Last name  |     |               |          |
| Address  |     |               | Postcode |
| Phone Number   |     |               |          |
| Email Address  |     |               |          |
| Your local authority   |     |               |          |
| GP name, address and phone number  |     |               |          |
| Please provide details of anyone else who lives in the applicant's household.  |     |               |          |
| Details of next of kin or emergency contact name, phone number/email address, and relationship to applicant (this can be the referrer) |     |               |          |
| Do you identify as Jewish?   | Yes | No            |          |

|   |                             |    |
|---|-----------------------------|----|
| <b>If you the applicant are completing this referral, please agree to the following: 'I consent to share my information and any reports with third parties such as occupational therapist, local authority, social worker and equipment suppliers.' Please note, without your consent, we will not be able to process your application.</b>   | Yes                         | No |
| <b>If you are completing this form on behalf of someone else, please note that we cannot proceed with the application unless they have given their consent. They must consent to this referral and to Jewish Blind &amp; Disabled sharing their information with third parties such as occupational therapists, local authorities, and equipment suppliers. Have the applicant given consent?</b> | Yes they have given consent | No |
| Would the applicant like us to share reports with anyone?   | Yes                         | No |
| If yes, please give details (including email):  |                             |    |
| Does the applicant have lasting power of attorney in place? Please give details here (including email):   |                             |    |

## ABOUT THE PROPERTY

|                                     |       |                            |  |                                    |
|-------------------------------------|-------|----------------------------|--|------------------------------------|
| Is the property<br>(please circle): | Owned | Rented<br>(Private Sector) | Rented<br>(Housing<br>Association/<br>Local Authority) | Other<br>(please specify<br>below) |
|-------------------------------------|-------|----------------------------|--|------------------------------------|

Other (Please detail below):

**Please note if your home is not privately owned, if our Occupational Therapists suggests any adaptations within your home, you will need to seek permission from your landlord.**

**Please tell us about your disabilities and any medical condition(s) and how they affect daily living.**

|  |     |    |
|--|-----|----|
| Has the applicant been an inpatient at a hospital in the past 12 months? | Yes | No |
| If yes, please provide brief details, dates and reason for admission:    |     |    |

|   |  |                   |        |          |
|---|--|-------------------|--------|----------|
| What floor is the property on?  |  | Is there a lift?: | Yes    | No       |
| Does the applicant struggle with internal or external stairs at home?               |  |                   | Yes    | No       |
| Does the property have a bath, shower or wet room?                                  |  | Bath              | Shower | Wet Room |
| Does the applicant struggle using the bathroom?                                     |  |                   | Yes    | No       |
| Does the applicant experience any difficulties accessing or using your kitchen?     |  |                   | Yes    | No       |
| Does the applicant struggle getting in and out of bed?                              |  |                   | Yes    | No       |
| Does the applicant struggle getting in and out of a chair?                          |  |                   | Yes    | No       |
| Does the applicant struggle getting in and out of a car?                            |  |                   | Yes    | No       |
| Is the applicant registered blind or partially sighted?                             |  |                   | Yes    | No       |
| Does the applicant have any form of hearing impairment?                             |  |                   | Yes    | No       |
| Have you noticed any changes to your memory or concentration recently?              |  |                   | Yes    | No       |
| If yes to previous question, please give more details - is this being investigated? |  |                   |        |          |

| Does the applicant use any of the following (please circle as appropriate) |              |            |                  |                        |                 |      |
|--|--------------|------------|------------------|------------------------|-----------------|------|
| Walking stick  | Zimmer frame | Wheelchair | Mobility scooter | 3 or 4-wheeled trolley | Kitchen trolley | None |

Does the applicant receive any care or help at home? If so, please give details below.

|  |
|--|
|  |
|--|

| Does the applicant receive any of the following benefits? (please circle as appropriate): |                |                      |                              |                        |                                |                  |
|---|----------------|----------------------|------------------------------|------------------------|--------------------------------|------------------|
| Housing Benefit   | Pension Credit | Attendance Allowance | Employment Support Allowance | Job Seeker's Allowance | Personal Independence Payments | Universal Credit |
| Other (Please detail below):  |                |                      |                              |                        |                                |                  |
|   |                |                      |                              |                        |                                |                  |

|  |     |    |
|--|-----|----|
| Has the applicant had or are they on a waiting list for an occupational therapy assessment?  | Yes | No |
| If yes, please provide details of when the last assessment was and who completed it, or if on a current wait list. (If currently on the wait list do you know when the assessment will be done?) |     |    |
| Details:   |     |    |

|  |     |    |
|--|-----|----|
| Does the applicant have a social worker or any other professional involved in care? If yes, please give details: | Yes | No |
| Details:   |     |    |

|  |     |    |
|--|-----|----|
| Does the applicant have any pets, or look after a pet for a friend or family member? | Yes | No |
| Details:   |     |    |

|  |     |    |
|--|-----|----|
| Does the applicant or anyone else who lives in applicant's property have any criminal convictions? | Yes | No |
| Details:   |     |    |

How did you hear about this service? Please tick where appropriate.

|                                 |                          |                      |                          |
|---------------------------------|--------------------------|----------------------|--------------------------|
| Jewish Blind & Disabled Mailing | <input type="checkbox"/> | Jewish Care          | <input type="checkbox"/> |
| Email                           | <input type="checkbox"/> | Recommendation       | <input type="checkbox"/> |
| Word of Mouth                   | <input type="checkbox"/> | Other (please state) | <input type="checkbox"/> |

Any other helpful information we should know?

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Are you happy to hear from Jewish Blind & Disabled about News and Events? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|---|------------------------------|-----------------------------|

## Signed Declaration

The information contained on this form is accurate to the best of my knowledge.

|                                       |                      |       |                      |
|---------------------------------------|----------------------|-------|----------------------|
| SIGNED APPLICANT 1                    | <input type="text"/> | DATE: | <input type="text"/> |
| SIGNED BY REFERRER<br>(if applicable) | <input type="text"/> | DATE: | <input type="text"/> |

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