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Mill Hill East,   
London, NW7 1GT

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Reg. Charity No. 259480

**INDEPENDENT LIVING ADVISORY SERVICE APPLICATION FORM**

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| --- | --- | --- | --- | --- | --- |
| **Who is completing this form (please circle):** | | **Myself** | **Note to referrer (If you are completing this form for someone else, please provide your details at the end of the application)** | | |
| Title & full name (applicant 1) |  | | | | |
| Date of Birth |  | | | | |
| Title & full name (applicant 2 if applicable) |  | | | | |
| Date of Birth |  | | | | |
| Address |  | | | | |
| Phone Number(s) |  | | | | |
| Email Address |  | | | | |
| Your local authority |  | | | | |
| GP name, address, and phone number |  | | | | |
| Details of next of kin or emergency contact name, phone number / email address, and relationship to you |  | | | | |
| Do you identify as Jewish? | | | | **YES** | **NO** |

|  |  |  |  |
| --- | --- | --- | --- |
| I consent for Jewish Blind & Disabled to share my information and any reports with 3rd parties such as Occupational Therapist, Local Authority, Social Workers, and equipment suppliers. | | **YES** | **NO** |
| If you are completing this form on behalf of someone else, please note we are unable to proceed with this application unless they have provided you with the consent for this referral, and for Jewish Blind & Disabled to share their information and any reports with third parties, such as occupational therapists, local authority and equipment suppliers. | | **YES** | **NO** |
| If you would like us to share reports with a  family member, please provide their details here: |  | | |
| Do you (or does your client) have Lasting Power  of Attorney? If so, please give full details here: |  | | |

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| Is your accommodation (please circle): | Owned | Rented (Private sector) | Rented (Housing Association/ Local Authority) |
| 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. | | | |

**About Your Home**

**Please tell us about your disabilities and any medical condition(s) and how it affects your day-to-day living.**

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| Applicant 1: |
| Applicant 2: |

|  |  |  |  |
| --- | --- | --- | --- |
| Which floor is your property on? |  | Is there a lift? |  |

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| --- | --- | --- | --- | --- |
| Do you struggle with internal or external stairs at home? | | **YES** | | **NO** |
| If so, please give details: | | | | |
| Do you have a bath, shower, or wet room? Please circle as appropriate. | **Bath** | | **Shower** | **Wet Room** |
| Do you struggle with any of these, or any other aspect of using your bathroom? Please provide details: |  | | | |
| Do you have any difficulties accessing or using your kitchen? Please provide details: |  | | | |
| Do you struggle to get in and out of bed? | | | **YES** | **NO** |
| Do you struggle getting in and out of your chair? | | | **YES** | **NO** |
| Do you struggle getting in and out of your car? | | | **YES** | **NO** |
| Are you registered blind or partially sighted? | | | **YES** | **NO** |
| Do you have any form of hearing impairment? | | | **YES** | **NO** |
| Have you had a referral to your local Sensory Services? | | | **YES** | **NO** |
| Have you noticed any changes to your memory or concentration recently? | | | **YES** | **NO** |
| Do you use any of the following (please circle as appropriate) | | | | |
| Walking stick / Zimmer frame / Wheelchair / Mobility Scooter / 3 or 4-wheeled walker / Kitchen trolley / Other (please detail below). | | | | |

**Do you receive any care or help at home? If so, please provide details below.**

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| Do you 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). |

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| --- | --- | --- |
| Have you ever had an Occupational Therapy Assessment? If yes, please send a copy of the report(s). | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| Are you currently on the waiting list for an Occupational Therapy Assessment? | **YES** | **NO** |
| Do you have a social worker, or any other professional involved in your care? If yes, please give details: | **YES** | **NO** |

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

|  |  |
| --- | --- |
| Jewish Blind and Disabled Mailing |  |
| Email |  |
| Word of Mouth |  |
| Jewish Care |  |
| Recommendation |  |
| Other (Please State) |  |

**Referrer Details (if applicable)**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship or Referring organisation** | **Phone number and email address** |
|  |  |  |

**SIGNED DECLARATION**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **SIGNED**  **APPLICANT 1** |  | **DATE** |  |
| **SIGNED**  **APPLICANT 2** |  | **DATE** |  |
| **SIGNED BY REFERRER  (if applicable)** |  | **DATE** |  |

**Any other helpful information we should know?**

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