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

Tel: 020 8371 6611 X620
Email: ila@jbd.org
Reg. Charity No. 259480

INDEPENDENT LIVING ADVISORY SERVICE APPLICATION FORM

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.

Who is completing this form (please circle):	Myself	Referrer

Referrer Details (if applicable)

Name	Relationship or Referring organisation	Phone number and email address

Applicant 1 Details

Applicant 1: Title		Applicant 1: First name	
Applicant 1: Last name			
Applicant 1: Date of birth			

Applicant 2 Details (if applicable and if a family member in your home also wants an occupational therapy assessment, please fill in their name)

Applicant 2: Title		Applicant 2: First name	
Applicant 2: Last name			
Applicant 2: Date of Birth			

Address		Postcode
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 applicant (this can be the referrer)		
Do you identify as Jewish?	Yes	No

So we can proceed with your 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.	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 they have given consent	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:		

Is your accommodation (please circle):	Owned	Rented (Private Sector)	Rented (Housing Association/ Local Authority)	Other (please specify)

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.

Applicant 1:				
Applicant 2:				
Which floor is your property on?:		Is there a lift?:	Yes	No

Do you struggle with internal or external stairs at home?		Yes	No
Do you have a bath, shower, or wet room? Please circle as appropriate.	Bath	Shower	Wet Room
Do you struggle using the bathroom?		Yes	No
Do you have any difficulties accessing or using your kitchen?		Yes	No
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 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 trolley	Kitchen trolley

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

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	Univeral 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:		

Do you have a social worker, or any other professional involved in your care? If yes, please give details:	Yes	No
Details:		

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

Jewish Blind & Disabled Mailing		Jewish Care	
Email		Reccomendation	
Word of Mouth		Other (please state)	

Any other helpful information we should know?

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:	

Details of our Privacy Policy can be found on our website www.jbd.org

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The key to independence