**WEXFORD COUNTY COUNCIL**

**DISABLED PERSONS ADAPTIONS**

**APPLICATION FORM**

**FOR WEXFORD COUNTY COUNCIL TENANTS**

**NAME OF APPLICANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please read the attached conditions prior to completing this form

All questions must be answered

Please write your answers clearly in block capital letters



# 1. Purpose of the Adaptation

The Disabled Persons Adaptation Scheme for tenants with a Disability is available to assist in the carrying out of works which are reasonably necessary for the purposes of rendering a house more suitable for the accommodation of a person with a disability who has an enduring physical, sensory, mental health or intellectual impairment.

The types of works allowable under the scheme include the provision of access ramps, downstairs toilet facilities, stair lifts, accessible showers, adaptations to facilitate wheelchair access, and any other works which are reasonably necessary for the purposes of rendering a house more suitable for the accommodation of a person with a disability.

**2. Appeals Procedure**

In processing application under the Disabled Persons Adaptation Scheme for tenants, the authority recognises that some applicants may be dissatisfied with the authority’s decision. The authority will give every applicant an appeal mechanism, which will allow him or her to have the decision in his or her case reconsidered by another official.

The following procedure shall apply to each appeal:

Applicants are invited to submit a written appeal on any decision notified to them by the local authority on their application within 3 weeks of the date of the decision stating the reasons for the appeal. The appeal will be considered and adjudicated upon within 4 weeks of receipt. A decision on an appeal will be notified to each applicant within 2 weeks of the decision being made.

# Checklist

Please ensure that the following documentation is included in the application:

* Fully completed application form (DPA);
* Completed G.P. Medical report (DPA2);

**If you require assistance in filling out this form please contact:**

**Housing Department**

**Tel: 053 9196000 or 053 9196694**

**Or**

**Your local Wexford County Council Office**

**Applicant:**

### Address:

**Eircode:**

**Telephone No: Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.P.S. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of person for whom the adaption is sought *(if different from Applicant):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to applicant:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the person with the disability residing at the address above: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has s/he been living at this address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and address of General Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­\_­­­­­­­­­­­­­­­­­­­­­­­­­­­**

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

**Details of all persons living in property for which the adaption is sought *(including applicant and/or person with a disability)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Relationship to applicant** | **Date of birth** | **Gross Income (previous tax year)** | **Occupation**  ***(if applicable)*** |
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**Number and description of rooms in the dwelling:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Bedrooms** | **Living** | **Dining** | **Kitchen** | **Other** |
| **Upstairs** |  |  |  |  |  |
| **Downstairs** |  |  |  |  |  |

**General description of proposed adaptation works:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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**Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Completed applications forms should be returned to:**

**HOUSING DEPARTMENT,**

**WEXFORD COUNTY COUNCIL,**

**COUNTY HALL,**

**CARRICKLAWN,**

**WEXFORD**

**Y35 WY93**

**DPA 2**

CERTIFICATE OF DOCTOR

HOUSING ADAPTATION FOR PEOPLE WITH A DISABILITY

# Definition of Disability:

In assessing this application Local authorities will have regard to the Disability Act 2005 which defines disability as follows:

*“disability”, in relation to a person, means a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment”.*

I hereby certify that the proposed works on the attached application form are necessary for the proper accommodation of: (**Please use Block Capitals**)

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**WHO SUFFERS FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NATURE AND DEGREE OF DISABILITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(PRINT IN BLOCK CAPITALS)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**YOU MUST INDICATE THE RELEVANT LEVEL OF DISABILITY APPLICALBE TO THIS APPLICANT BASED ON YOUR KNOWLEDGE/ASSESSMENT OF HIS/HER DISABILITY AND THE PROPOSED WORKS REQUESTED : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### (please state proposed works)

Priority 1

Terminally ill or fully/mainly dependant on family or carer; or where alterations/adaptations would facilitate discharge from hospital or alleviate the need for hospitalisation in the future;

Priority 2

Mobile but needs assistance in accessing washing, toilet facilities, bedroom etc; or where without the alterations/adaptations the disabled person’s ability to function independently would be hindered;

Priority 3

Independent but requires special facilities to improve the quality of life, e.g. separate bedroom/living space.

**NAME OF DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOCTOR’S STAMP**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**