



**West Lothian  
Council**

**APPLICATION FORM  
For  
HOUSING WITH CARE  
IN  
WEST LoTHIAN**



**: PART 1 :**

<b>Question 1 – Your Personal Details</b>	
<b>Mr</b> <input type="checkbox"/> <b>Mrs</b> <input type="checkbox"/> <b>Miss</b> <input type="checkbox"/> <b>Ms</b> <input type="checkbox"/>	<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>Name:</b>	
<b>Address:</b>	
<b>Postcode:</b>	<b>Telephone No:</b>
<b>Date of Birth:</b>	
<b>Marital Status:</b> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/>	

<b>Question 2 – West Lothian Council and partners operate a policy of equal opportunities. Please help us do this by ticking the box that best describes your ethnic origin</b>			
Scottish <input type="checkbox"/>	Other British <input type="checkbox"/>	Irish <input type="checkbox"/>	White other <input type="checkbox"/>
Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Chinese <input type="checkbox"/>
Asian other <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	Black African <input type="checkbox"/>	Black other <input type="checkbox"/>
Any other (describe):			

<b>Question 3 – Are you related to a member of staff or committee/board member of any of the following organisations?</b>		
	Yes	No
<b>West Lothian Council</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bield Housing Association</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dunedin/Canmore Housing Association</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hanover Housing Association</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Trust Housing Association</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If Yes, please tell us their name and relationship to you:</b>		

**Question 4 – If someone assisted you with this form, please tell us who they were**

Mr  Mrs  Miss  Ms

Name:

Address:

Telephone No:

Relationship to You:

**: PART 2 :**

**Please tick which of the developments named below you would like to live in**

- |                             |                          |                                |                          |
|-----------------------------|--------------------------|--------------------------------|--------------------------|
| Armada (Colinshiel Court)   | <input type="checkbox"/> | Blackburn (Almondvale Gardens) | <input type="checkbox"/> |
| Broxburn (Holmes Gardens)   | <input type="checkbox"/> | Dedridge (Crusader Court)      | <input type="checkbox"/> |
| Whitburn (Brucefield House) | <input type="checkbox"/> | West Calder (Dickson Court)    | <input type="checkbox"/> |
| Mid Calder (Cunnigar House) | <input type="checkbox"/> | Bathgate (Norvell Lodge)       | <input type="checkbox"/> |
- If you have no particular choice, tick this box:

**: PART 3 – YOUR CURRENT HOUSING CIRCUMSTANCES :**

**Question 1 - Please tick which best describes your present housing circumstances**

- |                              |                          |                            |                          |
|------------------------------|--------------------------|----------------------------|--------------------------|
| Council tenant               | <input type="checkbox"/> | Owner/occupier:            | <input type="checkbox"/> |
| Housing Association tenant * | <input type="checkbox"/> | Privately rented**         | <input type="checkbox"/> |
| *Name of Association:        |                          | **Landlord Name & Address: |                          |
| Living with Family           | <input type="checkbox"/> | Hospital                   | <input type="checkbox"/> |
| Other (please state):        |                          |                            |                          |

**Question 2 – Please tick the box that describes your reason for applying for housing**

Roofless/Homeless at Home	<input type="checkbox"/>	Accommodation too large	<input type="checkbox"/>
To move to another community	<input type="checkbox"/>	Accommodation too small	<input type="checkbox"/>
Breakdown of Family Support	<input type="checkbox"/>	Require different form of support	<input type="checkbox"/>
Accommodation in poor condition	<input type="checkbox"/>	Residential care now inappropriate	<input type="checkbox"/>
Hospital discharge	<input type="checkbox"/>	Breakdown of marriage/relationship	<input type="checkbox"/>
Other (please describe):			

**Question 3 – How long have you lived at your present address?**

Years                      Months

**Question 4 - If you are currently in hospital, when were you admitted?**

**Question 5 - How many bedrooms are in your present home?**

**Question 6 – What type of property do you currently live in?**

House       Flat       4 in a block       Other:

**Question 7 – How many stairs are there to you front door?**

**Question 8 – How many stairs are there to your back door?**

**Question 9 – Do you have stairs within your home?**

YES       NO

If YES, how many?

**Question 10 – Tell us how you manage the stairs?**

**Internal**

**External**

Without difficulty	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Only with assistance	<input type="checkbox"/>	<input type="checkbox"/>

**Question 11 – What type of heating does your current accommodation have?**

Gas Central Heating	<input type="checkbox"/>	Gas Fire Only	<input type="checkbox"/>
Coal Central Heating	<input type="checkbox"/>	Coal Fire Only	<input type="checkbox"/>
Electric Storage Heating	<input type="checkbox"/>	Other	<input type="checkbox"/>

**Question 12 – Overcrowding/Sharing**

**Tell us if you share any of the following in your current accommodation**

Living Room	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Kitchen	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bedroom	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Bathroom	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you answered YES to any of these options, please give details of who you share with:

**Question 13 – Do you have a garden?**

YES  NO

If YES, how well do you cope? Easily  With difficulty  Impossible to manage

**Question 14 – Do you have a pet?**

YES  NO

If YES, please give details:

**Question 15 – Do you have a car / and do you drive?**

YES  NO

**Question 16 – Do you suffer from harassment/security problems?**

YES  NO

If YES, is it: Once a week or less  More than once a week  Most days

**Question 16 – Please provide information about your previous addresses from the past 10 years**

<b>Address</b>	<b>Date From</b>	<b>Date To</b>	<b>Name &amp; Address of Landlord/Owner</b>	<b>Tenure – e.g. lodger, private tenant etc.</b>

**: PART 4 – YOUR HOUSING SUPPORT AND CARE NEEDS :**

**About Your General Health – Please tell us here if you suffer from any physical or mental frailty you consider relevant to your application**

**NOTE TO APPLICANT: TO ENABLE US TO FULLY UNDERSTAND YOUR CARE AND SUPPORT REQUIREMENTS, IT IS IMPORTANT FOR US TO ASK PERSONAL INFORMATION ABOUT;**

- **Your physical ability**
- **The level of assistance you receive from your family, home help etc.**

**The information you provide us in the following section of the form will be used to enable us to fully assess your needs.**

## HOUSING SUPPORT

Are you <u>able</u> to do any of the following tasks?	YES	NO
Are you able to collect your pension and pay your bills?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to do your general housework?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to clean your kitchen and bathroom?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to prepare your breakfast?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to prepare a snack?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to do your laundry including changing your bed linen?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to manage your medication?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to manage your own shopping?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Are you able to prepare your main meal?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, who does this for you?	Number of times per week?	
Do you attend a Day Centre or the Day Hospital?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, which one?	How often?	

**PHYSICAL ABILITY**

Please answer the following questions as best you can	YES	NO
Do you use a stick or walking frame to help you walk?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a wheelchair inside your home?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a wheelchair when you go outside your home?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fallen in your home?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a frame or rail by your toilet to help you on/off?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to get up from your chair?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to physically answer your front door?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to lift your legs onto the bed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to make a hot drink?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to hold a hot drink and walk at the same time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to stand at the sink to wash dishes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need assistance, from either equipment or another person, to take a bath or shower?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an accident because you were not able to reach the toilet on time?	<input type="checkbox"/>	<input type="checkbox"/>
If you have a catheter/stoma do you find it difficult to change?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need help to fill in forms etc.?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sometimes forget to turn the cooker off?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever forget what day it is?	<input type="checkbox"/>	<input type="checkbox"/>
Do you need to write things down in order to remember to do them?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever forgotten your address or telephone number?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have social contact outwith your household, <u>excluding</u> you home help? (please select from options below)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daily <input type="checkbox"/> Most but not every day <input type="checkbox"/> At least once per week <input type="checkbox"/> None		



## ABOUT YOUR PERSONAL SUPPORT

Please tell us who assists you with the following tasks and how often:

	Home Help	Family/ Carer	Self	Times per Week
Getting you out of bed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting you dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting you undressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting you into bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personal hygiene (washing/shaving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moving from bedroom to sitting room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you require any overnight care/assistance?	YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, who provides the overnight care/support you require?				

**: PART 5 – DECLARATION :**

I declare that the particulars given by me are true in every respect. I agree that, in accordance with the terms of its registration under the Data Protection Act 1998, the Council may use the information I have supplied;

- To contact other landlords to obtain reports on the conduct of my present tenancy and the conduct of previous tenancies I have had.
- To contact Social Services to request a social work assessment on my current care/support needs.
- To process my application form onto the computer database.
- To pass my name to other registered social landlords who can provide suitable accommodation to meet my housing and/or support needs.

<b>Applicant Signature:</b>	<b>Date:</b>
<b>Or signed on behalf of:</b>	<b>Date:</b>

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM**

**Finally, can you tell us where you heard about us?**

- GP MEDICAL CENTRE
- SOCIAL WORKER
- CUSTOMER INFORMATION SERVICES
- FAMILY / FRIENDS
- OTHER SOURCE (please specify)

When we receive your completed application form we will assess the hours of care and support you have said you need. If these are over 6 hours, your application form will be passed to the manager of the development you asked for via the tick box in Part 2.

An appointment will be made with you to visit you to discuss your care and support needs and if this is successful your name will be placed on the waiting list of your choice to await a vacancy.

**Please return this application form to:**

The Allocation Team,  
West Lothian Council,  
West Lothian Civic Centre,  
Howden South Road,  
Livingston,  
EH54 6FF