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For Official Use Only

Date rec’d:

Ident:

PID:

**Application for Home Safety Service**

**Please note:**

* The Telecare equipment will be supplied to you FREE of charge and this includes the follow up support from Home Safety Service staff.
* There is a weekly charge for the 24-hour, 7 day per week link to West Lothian Careline who monitor and access help for you when required, we will discuss this with you during the assessment.
* Home Safety Service is working in partnership with the Scottish Fire and Rescue Service. As part of our assessment process you will be contacted by a Community Fire Safety Officer who will arrange a time to visit you and carry out a free Home Fire Safety Visit.

**Data Protection**

West Lothian Council provides technology to support individuals to live independently at home. In order to provide this service the council needs to collect information about you and depending on the services and support you require, your family and other people involved.

All personal information is held and processed by West Lothian Council in accordance with Data Protection legislation. For more information, please refer to the ‘Data Protection and GDPR’ page of the council’s website or request a copy of the privacy notice by telephoning 01506 284440.

<https://www.westlothian.gov.uk/dataprotectionandprivacy>

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| --- | --- | --- | --- | --- |
| **Personal Details** | | | | |
|  | **Title** | **First Name** | **Surname** | **Date of Birth** |
| **1** |  |  |  |  |
| **Email:** | | | |
| **2** |  |  |  |  |
| **Email:** | | | |

|  |  |
| --- | --- |
| Address:  Postcode: | |
| Home Phone No: | Phone Provider: |
| Mobile Phone No(s): | |

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| Give details of anyone you wish to be present at the assessment/installation: |

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| **Property Details** | | |
| Is your property**:** Owner Occupier WLC Housing Partnership Rented | | |
| Landlord Name & Contact No: | | |
| Bungalow 2 storey house flat (upper or lower floor) Ground floor flat | | |
| Do you have a Keysafe? N | Location: | Keysafe No: |

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| Does anyone else live at this address?  **No** **If yes, give details below:** | | |
| **Name & Relationship** | **D.O.B** | **Medical Conditions** |
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| **Medical Details** | | | | | | |
| Doctors Name:  Address:  Post Code Phone No: | | | | | | |
| **Please detail any medical conditions you have:** | | | | | | |
|  | **Applicant**  **1** | **Applicant**  **2** |  |  | **Applicant 1** | **Applicant 2** |
| **Cardio/Vascular** | | |  | **General Condition’s** | | |
| Heart condition |  |  |  | **Cancer:**  Type  Currently having treatment  In remission  Cured |  |  |
| Angina |  |  |  |  |  |
| Circulation problems |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |
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| **Respiratory** | | |  | Diabetes & Type |  |  |
| Asthma |  |  |  | Epilepsy |  |  |
| Bronchitis |  |  |  | Blood disorder |  |  |
| Breathing difficulties |  |  |  | Arthritis |  |  |
| Oxygen at home |  |  |  | Osteoporosis |  |  |
| **Mind State** | | |  | Speech difficulties |  |  |
| Poor concentration |  |  |  | Allergies |  |  |
| Learning difficulties |  |  |  | Stroke/TIA |  |  |
| Memory loss |  |  |  | **Sensory** | | |
| Anxiety |  |  |  | Blind/Partially sighted |  |  |
| Mental health problems |  |  |  | Profoundly deaf/partial hearing |  |  |
| **Mobility** | | |  | Hearing aid |  |  |
| History of falls |  |  |  | Aids used: |  |  |
| Details (recently/frequency) |  |  |  |  |  |
| Recent decline in mobility |  |  |  |  |  |
| Do any of the above conditions require immediate assistance in an emergency? | | | | | | |
| **Is this referral to support ‘end of life’ care?**  Give details: | | | | | | **Y / N** |

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| Please list any other medical conditions you have or give additional details on conditions above. |  |
| Please detail any risks or other issues: |  |
| Do you regularly attend any clubs/groups? |  |
| Please detail any packages of care you have?  Include the agency name and times of day they attend. |  |
| Are there any family/religious/cultural issues that we should be aware of? |  |

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| **Keyholder’s** |

We require contact details of at least one key holder. A key holder may be contacted at any time of the day or night by Careline to assist you in an emergency or to relay important information regarding your welfare or whereabouts. Key holders can be family members, neighbours or friends and should ideally be able to attend (if required) within a recommended 45-minute maximum response time. Key holder’s may be called at your request or if there is any alert from a Telecare sensor and you do not confirm all is well.

Should your key holder contact details change or if, for any reason, a key holder is unable to help for a period of time, such as holiday’s, sickness etc., Careline must be advised of these changes immediately and, where necessary, of any temporary contact arrangements.

Please note – **BEFORE** completing the keyholder details below, you **MUST**:

* have gained the keyholder’s consent to provide their details,
* advise the keyholder they will be contacted by Careline to introduce themselves either via phone or email.

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| **Name** | **Address**  **(**including Postcode**)** | **Telephone no.** | | **Relationship** |
| NOK – |  | Home |  |  |
| Work |  |
| Mobile |  | Keyholder Y / N |
| Email: | | | | |
|  | | | | |
|  |  | Home |  |  |
| Work |  |
| Mobile |  | Keyholder Y / N |
| Email: | | | | |
|  | | | | |
|  |  | Home |  |  |
| Work |  |
| Mobile |  | Keyholder Y / N |
| Email: | | | | |
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|  |  | Home |  |  |
| Work |  |
| Mobile |  | Keyholder Y / N |
| Email: | | | | |
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|  |  | Home |  |  |
| Work |  |
| Mobile |  | Keyholder Y / N |
| Email: | | | | |

**Continue on a separate sheet if necessary.**

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| **Consent** | | |
| **I/we consent to the following:**   * Home Safety Service will contact me to carry out an assessment of needs and install Telecare equipment as deemed necessary. | | **Y / N** |
| * The equipment remains the **property of the Council** and can be removed at the Councils discretion and must be returned to the Council when I/we no longer require it. | | **Y / N** |
| * In an emergency situation, should it be deemed necessary to force entry to my home, I/we will not hold the Council liable for securing the property and any damages incurred. | | **Y / N** |
| * There will be a weekly charge of **£\_\_\_\_\_\_** for the 24-hour, 7 day per week link to Careline. | | **Y / N** |
| * SFRS_logoI/we agree to WLC passing my contact details to The Scottish Fire & Rescue Service who will contact me to carry out a free Home Fire Safety Visit. | | **Y / N** |
| * Would you like to be referred to the Advice Shop for an income maximisation check. | | **Y / N** |
|  | | |
| **If you are in agreement with the above, please sign and date below.** | | |
| **Applicant 1** Name: | Date: | |
| Signature: |
| **Applicant 2** Name: | Date: | |
| Signature: |

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| --- | --- |
| **If someone other than the applicant has completed this form, they must complete the section below:** | |
| Are there any known risks to visiting staff? (if yes, give details) | Y / N |
| Are there any issues regarding cognitive function or mental health (if yes, give details) | Y / N |
| Does anyone have Power of Attorney/Guardianship for the applicant? (if yes, give details) |  |
| Reason for referral: | |

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| **Is the applicant aware with this referral?** | Y / N |
| **Have you indicated which items the applicant is giving consent to in the ‘Consent’ section of the application form?** | Y / N |

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| **Referrer Name:** | Tel No: | |
| **Referrer Signature:** | | Date: |
| Please indicate your relationship to the applicant(s): | | |

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| **Returning the completed form** | |
| Completed application forms and Direct Debit mandates should be returned as below: | |
| **By Post:** | Home Safety Service  Support at Home Services  Strathbrock Partnership Centre  Broxburn, EH52 5LH |
| **By Email:** | [supportathomeservices@westlothian.gov.uk](mailto:supportathomeservices@westlothian.gov.uk) |
| **If you would like to discuss the service/application form, please contact us:** | Telephone – 01506 284440 (select option 1)  Monday – Thursday – 8.30am – 5.00  Friday – 8.30-16.00 |

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| **Payment** |

**How would you prefer to pay?** (Please tick) The easiest way to pay is by Direct Debit, if you wish to pay by this method, you must also complete a Direct Debit mandate supplied by Home Safety Service.

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| --- | --- | --- | --- | --- |
| **Monthly Direct Debit** |  |  | **Annual invoice** |  |

**Applicant Details**

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| --- |
| Name: |
| Address:  Post Code: |
| Contact Tel No: |
| Email Address: |

**Invoice and Billing Details (if different from applicant)**

|  |
| --- |
| Name: |
| Address:  Post Code: |
| Contact Tel No(s): |
| Email Address: |

**Declaration**

**I/we declare that I am aware that the Telecare equipment is provide to me free of charge and this includes the support of the Home Safety Service staff.**

**I/we also declare that I have been made aware of the following:**

* There will be a charge of **£\_\_\_\_** per week which is for the 24 hour a day, 7 day per week monitoring link to West Lothian Careline who will monitor and access help for me should the need arise.
* I/we will be invoiced annually, in advance. You may opt to pay by Direct Debit and this would be by monthly instalments by completing a Direct Debit mandate.
* Late or missed payments may be passed to an external collections agency.
* The weekly charge will still apply if I/we are away from home for any length of time i.e. in hospital/on holiday as the Telecare equipment & Careline will still be ‘monitoring’ the property.

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| --- | --- |
| Applicant Name: | Date: |
| Signature: |

|  |  |
| --- | --- |
| HSS Support Worker Name: | Date: |
| Signature: |

For official use only

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| Service commencement date: | |
| Ident: | PID(s): |