HOUSING ADAPTATION GRANT FOR PEOPLE WITH A DISABILITY – LOCAL AUTHORITY TENANTS ONLY.

CHECKLIST

Please ensure that the following documentation is included in the application for grant aid:

- ☐ Fully completed application form (LA/HAG1)
- ☐ Completed G.P. medical report (LA/HAG2)
- ☐ Evidence of Household Income from all sources;

Any queries in relation to the Scheme or completion of application form can be relayed to Housing Staff Members on 0761 06 5000.

Completed applications forms should be returned to:

HOUSING GRANTS SECTION
TIPPERARY COUNTY COUNCIL
CIVIC OFFICES, NENAGH, CO. TIPPERARY

CONDITIONS OF GRANT SCHEME

1. Purpose of Grant

The Housing Adaptation Grant for People 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
- Extensions, 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.

LA/HAG 1

HOUSING ADAPTATION GRANT FOR PERSONS WITH A DISABILITY

APPLICATION FORM

TIPPERARY COUNTY COUNCIL
LOCAL AUTHORITY TENANTS ONLY SCHEME

Please read attached CONDITIONS IN FULL prior to completing form.

Incomplete forms will be returned

Please write your answers clearly in block capital letters.

The person for whom GRANT AID is sought must occupy the house as his/her normal place of residence

Applicant: _____
(TENANT)

Address:

_____
_____
_____

Eircode: _____
Telephone No: _____ Mobile No: _____
(At least 1 contact number MUST BE provided)

Date of Birth:_____ P.P.S. No: _____

Occupation:_____

Tipperary County Council understands that you may wish to have some help or support from a relative or friend in making this application and gathering documentation. If you do, please provide contact details for this person here:

Name: _____

Address:_____

Telephone Number:_____ Mobile No:_____

(Please note that in nominating a contact person you consent to that person receiving copies of documentation on your medical needs and financial assessments).
Name of person for whom grant aid is sought *(if different from Applicant):*

_____

PPS Number (of person for whom grant aid is sought*): _____

Date of Birth:_____

Relationship to applicant:

_____

Is the person with the disability residing at the above address:- _____

How long has the person resided at above address?:_____

Name & Address of your Doctor:-

_____

(Please note that the attached Doctor's Certificate must be completed by your GP and returned with this form).

Details of ALL persons living in property *(including applicant):*

Name	PPS Number	Date of Birth	Relationship to Applicant	Gross Income (previous tax year)	Occupation *(if applicable)*

Gross Annual Household Income (Income in respect of all Household Members): €_____

I declare that the above amount is the only source of income

Signe:_____

Number and description of rooms in the dwelling:

	Bedrooms	Living	Dining	Kitchen	Bathroom	Toilet	Other
Upstairs							
Downstairs							

Description of proposed works:
(Works must be medically necessary – SEE CONDITIONS OF GRANT SCHEME)

_____
_____
_____

DECLARATION

An applicant may be excluded from consideration for a Housing Adaptation Grant for People with a Disability if he/she supplies false information or withholds relevant information.

I/We undertake to inform Tipperary County Council of any changes in circumstances since the date of application.

I/We hereby declare that the foregoing information is correct and I/We apply to Tipperary County Council for a Housing Adaptation Grant for People with a Disability.

I/We hereby authorise Tipperary County Council to make any official enquiries necessary to process this application.

The person for whom the grant is sought occupies the house as his/her normal place of residence.

Signature of Applicant: _____ Date: _____

Signature of Spouse/Partner: _____ Date: _____

CERTIFICATE OF DOCTOR

LA/HAG 2

HOUSING ADAPTATION GRANT FOR PEOPLE WITH A DISABILITY

I hereby certify that the proposed works on the attached application form are necessary for the proper accommodation of: **(PLEASE COMPLETE IN BLOCK CAPS)**

NAME: _____

ADDRESS: _____
_____

WHO SUFFERS FROM:_____

NATURE AND DEGREE OF DISABILITY:
_____
_____

PRIORITY CATEGORY AS PER TCC PRIORITY SCHEME :
Doctor to tick appropriate box and initial Priority.

- ☐_____ **EMERGENCY CASE: Where alterations/adaptations would facilitate the immediate discharge from hospital or alleviate the immediate need for hospitalisation following an immediate change in the applicants' circumstances arising from an accident, stroke, heart attack etc.**
- ☐_____ **PRIORITY1: Where applicants are terminally ill, or fully/mainly dependent on family or carer; or where alterations/adaptations would facilitate discharge from hospital or alleviate the need for hospitalisation in the immediate 12 month period.**
- ☐_____ **PRIORITY2: Where applicants are mobile but need 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.**
- ☐_____ **PRIORITY3: Where applicants are independent but require special facilities to improve the quality of life, e.g. separate bedroom/living space.**

Note: In prioritising an application as an "Emergency Case" it is necessary to specify the reason for your decision with reference to the above definition by ticking one of the following options:

- ***Would the alterations/adaptations alleviate the immediate discharge from hospital***
  OR
- ***Is there an immediate need for hospitalisation following an immediate change in the applicant's circumstances arising from car accident, stroke, heart attack, in the absence of the alterations not being undertaken.***

Comments:-_____
_____

Name of Doctor: _____ **DOCTOR'S STAMP:**

Address of Doctor:_____
_____

Signature of Doctor:_____**Date:**_____

Please ensure that Certificate is Stamped by Doctor