APPLICATION FORM FOR MOBILITY AIDS HOUSING GRANT

Sligo County Council

Please read the attached conditions prior to completing this form

ALL QUESTIONS MUST BE ANSWERED

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

Please write your answers clearly in block capital letters

Works must not commence prior to receipt by the Local Authority of the grant application and written approval from the Local Authority

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

Checklist

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

- Fully completed application form ☐
- Completed G.P. Medical report (Pg 9) ☐
- Occupational Therapist Report supporting application **(Please see point 7 on notes attached)** ☐
- Evidence of Household Income from all sources ☐
- PROOF OF ADDRESS/RESIDENCY AT PROPERTY: e.g. Utility bill ☐
- PROOF THAT YOU HAVE PAID LOCAL PROPERTY TAX: copy of receipt ☐

Conditions of Scheme

1. Purpose of Grant

The Mobility Aids Housing Grant is available to cover a basic suite of works to address mobility problems, primarily, but not exclusively, associated with ageing. The works grant aided under the scheme include:

- Grab-rails;
- Access ramps;
- Level access showers;
- Stair-lifts; and
- Other minor works deemed necessary to facilitate the mobility needs of a member of a household.

2. Level of Grant

The effective maximum grant is €6,000 or 100% of the cost of the works, whichever is the lesser. The grant is available to households whose gross annual household income does not exceed €30,000.

3. Household Income

Household income is calculated as the property owner's annual gross income in the previous tax year, together with that of his or her spouse/partner, if applicable and all other household members' income.

In the case of private rented accommodation, household income is calculated as the tenant's annual gross income in the previous tax year, together with that of his/her spouse, if applicable and all other household members' income.

In determining gross household income local authorities shall apply the following disregards:

- €5,000 for each member of the household aged up to age 18 years;
- €5,000 for each member of the household aged between 18 and 23 years and in full time education or engaged in a FAS apprenticeship; - please submit letter from college/FAS centre.
- €5,000 where the person for whom the application for grant aid is sought, is being cared for by a relative on a full-time basis;
- Child Benefit;
- Early Childcare Supplement;
- Family Income Supplement;
- Domiciliary Care Allowance;
- Respite Care Grant;
- Carer's Benefit / Allowance (where the Carer's payment is made in respect of the person for whom the application for grant aid is sought).

4. Evidence of household income

The following evidence of income must be included with all applications:

- In the case of PAYE workers, P60 or Balancing Statement for the previous tax year;
- In the case of self-employed or farmers, Income Tax Assessment form, together with a copy of accounts for the previous tax year;
- In the case of social welfare recipients, a statement from Social Welfare stating weekly/annual payments or a receipt from post office. In the case of State Pensioners, a copy of a current receipt from post office will suffice.
- Documentary evidence of income for all other members of the household.
  (Evidence of household income should be submitted in respect of all household members)

5. Local Property Tax

Please provide evidence that you have paid the local property tax, i.e. submit copy of receipt with your application. See page 6 of application.

6. Appeals Procedure

In processing applications under the Mobility Aids Housing Grant Scheme 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.

7. Occupational Therapist Report

If you are currently an existing service user of the Occupational Therapy Department in HSE, Markievicz House, please submit an up to date report to support your application.

If you **are not** an existing service user of the Occupational Therapy Department, HSE, Markievicz House, please contact a private Occupational Therapist by accessing the website www.aoti.ie (Association of Occupational Therapists of Ireland) or contacting (01) 874 8136. The cost of engaging a **private** Occupational Therapist will be recouped to the applicant as part of the percentage of grant paid (subject to a limit of e200).

8. Disclaimer

Sligo County Council is not responsible for, and hereby excludes all liability (including in respect of any direct, indirect or consequential loss or damage), what so ever arising out of or in connection with (i) any defects in any works or services undertaken under Sligo County Council's Private Housing Grant Scheme(ii) any damage caused and (iii) any acts, omission or negligence. Guarantee(s) should be provided by your nominated building contractor or service provider before works are started in your home. Please note that you are solely responsible for ensuring that you are provided with the Guarantee(s). If there is any problem with or defects in the works, you should ask the building contractor or service provider to remedy the defect in accordance with the Guarantee(s) provided to you. If you do not understand the implications of the above, we recommend that you get independent legal advice.

MOBILITY AIDS GRANT – APPLICATION FORM

Works must not commence prior to receipt by the Local Authority of the grant application and written approval from the Local Authority

Applicant: _____

Address: _____

_____

_____

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

Telephone No:_____ **Mobile No:** _____ **And/Or**

Mobile phone number for family member or friend who can be contacted on your behalf:

_____

Note: Grant inspections are carried out in batches within a particular area. The provision of a mobile phone number helps site staff greatly when arranging meetings and inspections for your application within your area.

Occupation: _____

Name of person for whom grant aid is sought & Date of Birth & PPS No. ***(if different from Applicant):***

_____

Relationship to applicant: _____

Address of house where work is to be carried out: _____

Name of the owner of the property to which the proposed adaptation works are to be carried out:
(Please write the owners name in space provided)

_____

If a tenant, have you consent of owner to do the work? Yes _____ No _____
(Please submit a letter of consent from landlord/landlady in relation to carrying out works requested)

Gross Annual Household Income: € _____
(Please refer to explanatory note 3 & 4 above) Please submit documentary evidence of income

If in receipt of carers benefit/allowance, is payment in respect of the person for whom the grant is sought: YES _____ NO _____ N/A _____

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

How long has she/he been living at this address: _____
(Please submit proof of address/residency: e.g. Utility bill)

How long has he/she been disabled: _____years

Name and address of General Practitioner: _____

_____

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

Name and address of Occupational Therapist (Please submit OT report) NB: An OT report must be submitted. Please see point 7 on the notes on front of application

_____

_____

(Please note that the attached doctor's medical certificate must be completed by your G.P. and returned with this application form. Please also enclose Occupational Therapist's Report with the application).

How many residing in house: _____

Details of all persons living in property for which grant aid is sought (including applicant and/or person with a disability & all other household members')
For those aged between 18 and 23 years and in full time education or engaged in a FAS apprenticeship, please submit letter from college/FAS centre stating same.

Name	**Relationship to applicant**	**Date of birth**	**Gross Income (previous tax year)**	**Occupation** ***(if applicable)***

Number and description of rooms in the dwelling:

	Bedrooms	**Toilet**	**Bath/ Shower**	**Living**	**Kitchen**	**Dining**	**Other**
Upstairs							
Downstairs							

General description of proposed works:

_____

_____

_____

_____

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

_____

_____

PROOF THAT YOU HAVE PAID LOCAL PROPERTY TAX:

Submit copy of receipt/acknowledgement number: _____

Date of payment**:**_____

I understand the purpose of this grant and undertake to abide by the terms of this scheme. I have also read the disclaimer on page 3 of application form.

Signature of Applicant: _____ Date: _____

Completed applications forms should be returned to:

The Housing Section, County Hall, Riverside, Sligo

If you have queries on this form please contact:

Marcella Healy, Housing Section, County Hall, Riverside, Sligo

Tel: 071-911-1803.

CERTIFICATE OF DOCTOR

MOBILITY AIDS HOUSING GRANT SCHEME

(Please ensure that your doctor completes this medical certificate in BLOCK CAPITALS in a legible format)

I hereby certify that the proposed works on the attached application form are necessary for the proper accommodation of:

NAME: _____

ADDRESS: _____

_____

_____

WHO SUFFERS FROM: _____

_____

DESCRIPTION OF MOBILITY PROBLEM: _____

IS APPLICANT CONFINED TO WHEELCHAIR? **Yes** _____ **No** _____

NATURE AND DEGREE OF DISABILITY – PLEASE TICK ONE OF THE FOLLOWING PRIORITY LEVELS OTHERWISE THIS CERTIFICATE WILL BE RETURNED AND THE APPLICATION WILL BE DEEMED INVALID

Priority 1 ☐
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 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 basic works due to minor mobility issues.

NAME OF DOCTOR: _____

DOCTOR'S STAMP

ADDRESS: _____

_____

SIGNED: _____

DATE: _____