



Housing With Care Application Form

Please Complete and Return to:

C/O Scheme Manager
Cherryfields Housing-with-Care
2 Cherryfields Lawn
Hartstown
Dublin 15

This application form affords you, the Applicant, the opportunity to explain your circumstances and reasons for applying for Housing with Care.

Fold Ireland Ltd allocates Housing with Care dwellings in accordance with a Lettings Policy approved by the Department of the Environment. Allocations are made on the basis of greatest assessed need.

All information given by you on this form will be treated as confidential but will be shared with the Health Service Executive or Fingal County Council who may contact you.

Fold Ireland is working in Association with: -

Application form for _____

Name of Applicant:

Mr/ Mrs/ Miss/Ms -----

Name of Partner (if applicable) -----

Present Address -----

----- Telephone Number -----

Dates of Birth -----

PPS Numbers -----

Do you hold a medical card? Yes/No

Please indicate your current tenure at the above address as:

1. Owner Occupier
2. Local Housing Authority Tenant Please Specify Council
Area -----.
3. Private Rental Tenant.
4. Tenant of a Voluntary Housing Association.
5. In Lodgings.
6. Living with Family/ Friends
7. Other: Please Specify -----.

Please state how long you have lived at the above address: -----

-----.

Please state any previous address -----

(Within 5 years)

Is your current home?

1. A two or more storey dwelling.
2. A bungalow.
3. A Flat: Please state floor level: -----.
4. A residential care facility.
5. A nursing home.
6. Other: Please specify: -----

How many rooms are there in your present home? -----

How many bedrooms are there in your present home? -----

How many rooms do you occupy? -----

Do you have use of a flush toilet, a bath or a shower? Yes/No

Who else lives in your home? -----

Are they Male ----- or Female -----

What is the rent for your present accommodation? € -----

Do you have a rent allowance? € -----

If you consider your present home as unsuited to your needs,
please tell us why?

Have you ever been a tenant of Fingal County Council or any
other Local Authority or Housing Association? Yes/No

If Yes, please state which Local Authority. -----

If Yes, please state address -----

Have you, or anyone now living with you, ever owned any house or premises? Yes/ No

If Yes, please give details. -----

Have you, or anyone living with you, applied to Fingal County Council for accommodation? Yes/No

If Yes, please state date applied -----
Address applied from -----

Your Finances:

Please tell us about your weekly/monthly income:

What is your total weekly/monthly income? € -----.

Do you receive a pension? Yes/No

How much is your pension? € -----.

Do you receive any Social Welfare Benefits? Yes/No.

Please state, which benefits and the amount paid for each:

----- € -----.

----- € -----

Do you have any other source of income? Yes/No

If so, please state source -----

Amount € -----

(By other income we mean income derived from the rental of property or land, from savings, stocks, bonds, shares or other investments).

Do you own your own home or other property? Yes/ No.

Please state if you are the sole owner or if someone else has a financial interest in the property.

What is the approximate value of your property? € -----

Do you have a mortgage or other loan secured on your property?
Yes/No.

If yes, how much has yet to be paid? € -----.

Do you have any savings? Yes/No

If yes, how much? € -----.

If you currently reside in a dwelling that you rent from a Council or Private Landlord, please state that your rental account is clear? Yes/ No.

Is there any further information regarding your finances that you feel will demonstrate your ability to pay for Housing with Care accommodation and that you would want to share with Fold Ireland?

Professional Contacts:

Your Doctor's Name: -----

Surgery Address: -----

Telephone Number: -----

Do you have a Social Worker? Yes/No.

If Yes, Name -----

Telephone Number: -----

Do you receive care from Public Health Nursing Services?
Yes/No.

If yes, please tell us what regular treatment you receive?

To be signed by the Applicant:

I declare that, to the best of my knowledge, the information given in this application is true and correct.

Signed: ----- . Date: -----.

Where this application has been completed on behalf of the applicant, please state:

Name of Person completing application: -----.

Address of Person completing application: -----

Contact Telephone Numbers for Person completing application:

Relationship to Applicant: -----

.

Correspondence to be addressed to (if different from above)

-----.