# medium logoMINOR ADAPTATION REFERRAL FORM

**(Rapid Response Adaptation Programme /Care & Safety/Safety at Home)**

#### CARE & REPAIR MONMOUTHSHIRE & TORFAEN

### CLIENT DETAILS:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **TITLE:** |  | | **FORENAME(S):** | | | | |  | | | | | **SURNAME:** | | | |  | | | | | | | | |
| **ETHNICITY:** | | **White** | | | | **Asian/Asian British** | | | **Mixed/Multiple ethnic groups** | | **Black/African/Caribbean/Black British** | | | | | | | **Other ethnic group** | | | | **Prefer not to say** | | | |
| **DATE OF INITIAL CONTACT:** | | | | |  | | | **DATE OF ASSESSMENT:** | | | |  | | | | **DATE NEED IDENTIFIED:** | | | | | |  | | | |
| **ADDRESS**  **(Please include Postcode):** | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **TEL NO:** | | | |  | | | | | | | | | | | | | **DATE OF BIRTH:** | | | | |  | | | |
| **WHO OWNS THE PROPERTY?** | | | | OWNED BY CLIENT | | | | | | PRIVATE TENANT  \*Please give landlord details below. | | | | | | | HOUSING ASSOCIATION  Please specify. | | | | | | | | |
|  | | |  |  | | | |  | |  |  | | | | Bron Afon Community Housing | | | | | |  | | |  |
|  | | |  |  | | | |  | |  |  | | | | | |  | |  |  | | | |  |
| **\*Landlord’s Contact Details:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **ARRANGEMENTS FOR ACCESS TO THE CLIENT’S HOME:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **KNOWN RISKS TO LONE WORKERS? (Please specify)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL: (Please do not write anything here)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **WILL THIS WORK ASSIST HOSPITAL DISCHARGE?**  We will aim to complete the work by date of discharge. | | | | | | | | | | | | |  | | | | **\*Discharge Date:** | | | | |  | | | |
| **\*IF YOU NEED TO BE INFORMED WHEN WORK HAS BEEN COMPLETED, PLEASE GIVE DETAILS OF WHO TO CONTACT (HOSPITAL DISCHARGE ONLY)** | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| **IS THE CLIENT “AT RISK”?**  We will aim to complete this work within 15 working days**.** | | | | | | | | | | | | | | | | | | | |  | | | | | |

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| **ON BEHALF OF MONMOUTHSHIRE OR TORFAEN HEALTH /LOCAL AUTHORITY I CONFIRM THAT THIS IS AN APPLICATION FOR A MINOR ADAPTATIONS GRANT OF UP TO £350 FOR THE FOLLOWING WORK TO BE CARRIED OUT:**  Please detail below a description of work required **giving approximate measurements** where appropriate - (Technical advice available on request) Please consider the height/weight of client when making requests. |

**WORK REQUIRED: (Please do not write anything here)**

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| **IS THERE ARTEX OR ANY TEXTURED COATING (NOT INCLUDING WALLPAPER) PRESENT ON THE SURFACE WHERE WE WILL NEED TO FIX THE ITEMS REQUESTED?**  **(Textured coatings may contain asbestos and can only be drilled into by licensed contractors - Failure to identify at referral stage may delay the completion of this work)** |  |
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| **KEY SAFE CODE (for key safe installations – no repeat digits please)** |  |

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| **CLIENT AUTHORISATION**  **The client must be made aware of the following conditions by the referrer before this referral can be made. By giving authority the referrer is agreeing this has been done.**  **THE CLIENT MUST –**   * consent to the work being done and that photographs of the property may be taken before and after the work for teaching or exhibition purposes (no names or addresses would be disclosed) * agree to accept responsibility for arranging and meeting the cost of maintaining, servicing, insuring or removing the work in the future. (The work undertaken has a 12 month warranty from date of installation.) * agree that their personal information can be given to Care & Repair * consent that they willingly apply for the grant. * understand the conditions under which the grant is offered and they understand and accept the disclaimer. * agree to the referrer referring their case to Care & Repair Monmouthshire & Torfaen to arrange for the work specified to be carried out. * confirm their tenure.  Disclaimer I understand and accept that the work is undertaken by Care & Repair Monmouthshire & Torfaen in good faith, and that upon my confirmation of satisfaction with the work, all responsibility of Care & Repair Monmouthshire & Torfaen or associated bodies is discharged. |

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| **REFERRAL AUTHORISED BY:** | | Verity Samuel | | | |
| **JOB TITLE:** | | Occupational Therapist | | | |
| **CONTACT NUMBER(S) – (please include mobile number)** | | 07528965160 | | | |
| **EMAIL ADDRESS:** | | Verity.samuel@bronafon.org.uk | | | |
| **DESIGNATION** (PLEASE **’X’** ONE OF THE FOLLOWING)**:** | | HEALTH |  | SOCIAL SERVICES |  |
| REABLEMENT |  | MCC |  |
| OTHER (PLEASE SPECIFY) | **Bron Afon Commuity Housing** | | | | |
| **DATE OF REFERRAL TO CARE & REPAIR:** | | |  | | |