



WPH ADAPTATIONS SELF - ASSESSMENT FORM

For WPH Use.

ADAPTATION REQUEST

THE APPLICANT/S DETAILS:
(The person/s who needs the adaptation)

Date:
In person (indicate ✓)
By Phone

| | | | | | | | | |
|---|------|--|--------|--|------|--|--------|--|
| 1 | Name | | D.O.B. | | Male | | Female | |
|---|------|--|--------|--|------|--|--------|--|

| | | | | | |
|----------|--|-----------|--|------|--|
| Address | | Prop Size | | Type | |
| Postcode | | | | | |

| | |
|---------------------------|--|
| Contact Telephone Numbers | |
|---------------------------|--|

| | | |
|---|---|--|
| 2 | Please enter date tenant moved into property (Year and month) | |
|---|---|--|

PLEASE NOTE – MAJOR adaptations will not be undertaken within the first 12 months of tenancy. - If any doubt – Please contact the Adaptations Team

| | |
|---|---|
| 3 | Name/contact details of person making request if different from above e.g. son, niece, Soc.wkr. |
| | |
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| | | | | | |
|---|-------------------------------------|--|------------|--|----------------|
| 4 | Does anyone else live in this home? | | | | |
| | No | | Yes | | Number |
| | | | | | |
| | Spouse | | Daughter/s | | |
| | Son/s | | | | |
| | Other/s (State) | | | | |
| | Do they have a disability too? | | | | |
| | Yes | | No | | If yes, detail |

| | | | | | |
|---|---|--|----|--|----------------|
| 5 | Has the applicant or any members of your family served in the armed services? | | | | |
| | Yes | | No | | If yes, detail |

6 Please describe what adaptation you would like us to consider doing for you and in what location?

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7 Please outline your disability and why you need this adaptation? E.g. improve mobility, bathing

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8 If, shower is required can you get on/off a chair that has arms?(max. 20 stone weight capacity)

| | | | |
|-----|--|----|--|
| Yes | | No | |
|-----|--|----|--|

9 Would you consider moving to a more suitably adapted property? If so, WPH will pay for the removal and other reasonable costs.

| | | | |
|-----|--|----|--|
| Yes | | No | |
|-----|--|----|--|

10 Did any person or agency recommend that an adaptation would be helpful?

| | | | | | |
|----------------------|--|-----------------------|--|-------------------|--|
| Occupation Therapist | | Hospital | | GP | |
| Other Specialist | | Carer/support Officer | | Relative | |
| Neighbour/friend | | Social Worker | | Other (State Who) | |

For above please provide:

| | | | |
|------|--|---------|--|
| Name | | Contact | |
|------|--|---------|--|

11 Have previous adaptations been carried out in your home?

| | | | | | |
|----|--|-----|--|------------|--|
| No | | Yes | | Don't Know | |
|----|--|-----|--|------------|--|

If yes, what & approximate date.

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12 What is the name & Address of the applicant's G.P.

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WPH Initial Evaluation

- 1. Minor - if approved usually provided within 10 days
- 2. Major - if approved usually provided within 3-6 months

WPH STAFF – PLEASE COMPLETE

Sign & Date

Print Name:

Team:

Tel.No: