ROSEHILL HOUSING ASSOCIATION

APPLICATION FOR GARDEN ASSISTANCE

Important Notes

All questions in the application form and medical self-assessment form must be completed. Any forms returned with blank sections will not be processed and will be returned to the tenant for full completion.

A medical self-assessment form must be completed for each household member who is claiming to be medically unfit to carry out garden maintenance, if applicable.

Before completing the forms please read the attached Garden Assistance Policy carefully.

Section One

Name : _____

Address : _____

House Size : _____

House Type : _____

Details of all those residing at this address (starting with yourself) :

Name	***Relationship to Tenant***	***Date of Birth***	***Sex***

Section Two

Work required (tick as appropriate):

	Front Garden	Back Garden	Side Garden
Grass Cutting			
Hedge Trimming			

Other (please specify):

_____

_____

_____

_____

_____

Section Three - **Declaration**

I understand the conditions which apply to the garden assistance scheme and would confirm all the information provided by me is true and accurate. I agree to advise the Co-operative immediately of any changes in my circumstances which may affect my eligibility for the scheme. I am aware that any false or misleading information or information deliberately withheld will result in my name being removed from the scheme/waiting list.

Signature: _____ Date: _____

OFFICE USE ONLY

Tenancy Agreement checked : YES / NO Update Required : YES / NO

Has the medical self-assessment form(s) been completed and attached: YES / NO

Application : ACCEPTED/REJECTED

Checked by: _____ Date : _____ Verified by: _____ Date: _____

MEDICAL SELF-ASSESSMENT FORM

Tenant Name: _____ Date of Birth: _____

Address: _____

_____

Other household member's details (if applicable)

Name: _____ Date of Birth: _____

Relationship to tenant: _____

Details of Garden

Do you have? (Please tick as appropriate)

Small front garden	☐	Small back garden	☐	Small side garden	☐
Large front garden	☐	Large back garden	☐	Large side garden	☐

Do you have hedging? (Please tick as appropriate)

Front garden ☐ Back garden ☐ Side garden ☐

Does your garden have any of the following features:
(please tick all that are appropriate)

Steps leading up to back garden	☐	If yes, how many steps	_____
Upward slope in back garden	☐		
Downward slope in back garden	☐		
Downward slope in front garden	☐		
Generally ground unlevel	☐		

Details of your condition/disability

Name:

Nature of condition/disability

How long have you been suffering from this disability/ill health — Years _____ Months _____

Medication/treatment ï copy of drug name and medicine

Are mobility aids used e.g. wheelchair, stick etc — Yes ☐ No ☐

Does applicant use the aid — Regularly ☐ occasionally ☐

If your aid is a wheelchair do you use it — Outside home only ☐

Inside and outside ☐

How does your health/medical condition or disability prevent you from operating garden equipment e.g. lawn mower, hedge cutters

How does your health/medical condition or disability prevent you from raking up and bagging grass/hedge cuttings

How does your health/medical condition or disability prevent you from lifting items of weight e.g. bags of refuse, garden equipment

If there are reasons other than the above why you are unable to maintain the garden, please explain:

Medical Care & Support

Do you have an occupational therapist? YES / NO

If YES, please give details:
Name: _____
Address: _____
_____
Telephone No: _____

Do you have a home help? YES / NO
If YES, how often? _____

Do you consider yourself to be disabled? YES / NO

Do you receive any allowances or benefits because of your Disability? YES / NO
If YES, please give details _____
_____

Do you attend the hospital/clinic as an outpatient? YES / NO

If YES, please give details:
Name of Hospital/Clinic: _____
How often do you attend? _____
Name of Consultant _____
Do you have family support? YES / NO

If YES, please give details:
Name _____
Address: _____
Relationship to you _____

Please give details of the support they give to you _____
_____
_____
_____

Name of family doctor _____
Address _____
_____
Tel No _____

Further Information

Please add any further information regarding your medical condition you think appropriate:

_____

_____

_____

_____

Data Protection

I hereby give Rosehill permission to contact my GP/Consultant/Social Worker if further information is needed regarding my health.

I understand that any information obtained will be held in the strictest confidence and will be used for the sole purpose of assessing my need for garden assistance. I also understand that any information held will not be passed on to a third party without my prior written consent.

Signed: _____ Date: _____

Declaration

I hereby certify that all information given by and statements made by me/us are true and accurate and that any false or misleading information deliberately withheld will result in my name being removed from the scheme or waiting list.

Signed: _____ Date: _____