HEALTH SERVICES EXECUTIVE- SOUTHERN AREA

PHYSICAL & SENSORY DISABILITY SERVICES

APPLICATION FOR COMMUNITY INCLUSION – HOME SUPPORTS/ASSISTED LIVING SERVICES

APPLICANT DETAILS

Name: _____ D.O.B.: _____

Home Address: _____

Contact details. (Please provide a contact number where you can be reached. An e-mail is also very useful.)

Land line: _____ E-mail: _____

Next of Kin – _____

Name: _____

Contact No _____

Relationship: Spouse/Civil Partner ❒ Partner ❒Son / Daughter ❒ Parent: ❒ Friend

To the PHN: *This application is being submitted on behalf of the above named. It is important that the applicant meets the criteria for the service and that it is submitted with the full informed and signed consent of the person for whom the application is being made or their parent/ guardian if the application is on behalf of a minor. Additional supporting assessment or report may be attached with the applicants' and authors consent. The applicant or their parent/ guardian in the case of a minor is required to sign the application. Applications must be supported by the A/PHN and submitted for attention of the:* ***Home Support Manager Cork, Home Support Office, Room Number FF 22, 1st Floor, Block 8, St. Anne's Ward, St. Finbarr's Hospital, Douglas Road, Cork****. An application is not a guarantee of service and a prioritised waiting list is operated. Please complete each section.* ***Please type****. Incomplete or unsigned applications cannot be progressed and will be returned to you.*

IMPORTANT Notes to the Applicant

This application is for Assisted Living Personal Assistant Services. The information will enable us to assess your application and better understand the supports that you have identified you would like. The application is not confirmation of a service provision. The ALS service is funded to an agreed level and as service demand exceeds the availability, we operate a prioritised waiting list.

All information supplied by you will be held on the HSE and Cork CIL data bases. It will be kept strictly confidential. Cork CIL will only use the information for the purpose for which it is supplied. There are laws that ensure information is not shared carelessly and that your rights are protected. These include GDPR The Data Protection Act 2018, The Data Protection Act 1998 & 2003, Freedom of Information Act 1997, and the Common Law Duty of Confidence. In signing this application, you are consenting to Cork CIL storing and using your data.

To enable us to consider your application fully, we may need to share information with other people/agencies, or others may need to share information with us. In signing this application, you are consenting to this application and the sharing of information as appropriate. The application **MUST BE SIGNED BY YOU OR YOUR ADVOCATE IN YOUR PRESENCE** as appropriate for us to proceed

LPC Office Use Date received AS PER STAMP Date LPC ❒❒/❒❒/❒❒❒❒

Present: _____

Decision: Not eligible ❒Ref to wait list ❒ Ref HH❒ other: _____

Information about your current services

General Practitioner

Name: Address_____Tel: _____

Public Health Nurse:

Name: _____Tel: _____

Therapy supports – please tick all which apply

Psychiatrist

Neurologist

Psychiatric Social Work / CMHN

Physiotherapist community ❒ hospital ❒ other ❒ (state)_____

Occupational Therapist community ❒ hospital ❒ other ❒ (state)_____

Speech & Language Therapist community ❒ hospital ❒ other ❒ (state)_____

Psychologist community ❒ hospital ❒ other ❒ (state)_____

Dietician community ❒ hospital ❒ other ❒ (state) _____

Chiropody community ❒ hospital ❒ other ❒ (state) _____

HSE Home Support Services [Home Help]

Personal Care ❒ Hours p w _____Days _____

Other ❒ Hours p w _____Days _____

Enhanced Home Support ❒ Hours pw _____Agency _____

Other Services Please tick all which apply and state what type and quantum of service e.g. Day Service/ Residential /Respite/ Therapy Advocacy / Advice PA Pre-school etc. /

Abode	Headway
BOC	IWA
Cork Assc. Deaf	MDI
Cheshire	MS Society
COPE	NCBI
Cork CIL	Rehab / NLN
Enable Ireland	Other

Accommodation (please✓)**:**

House ❒ Bungalow ❒ Apartment ❒ Supported Accommodation ❒ Other ❒

Lives alone ❒ with Family ❒ Other Relative ❒

Is the house adapted? YES ❒ NO ❒ Please state: _____

Is there a hoist or other equipment? YES ❒ NO ❒ Please state: _____

Assessment

Primary Disability: _____

Associated Conditions: _____

_____

Other health issues _____ _____

What do you need assistance with? E.g. Shop ❒ Planned appointment ❒ Work ❒ Study ❒ Recreation ❒ Spiritual Observance ❒ Other _____

Mobility:

Manual Wheelchair	❒ Power chair ❒ Walking Aid ❒ Stick ❒	
Mobility – inside	Yes ❒No ❒	grab rails, walking aid etc. _____
Mobility – outside	Yes ❒No ❒	wheelchair for distance mobility
Transfer - in/out bed	Yes ❒No ❒	Hoist / slide sheet / slide board
Transfer - in/out chair	Yes ❒No ❒	Hoist / slide sheet / slide board
Transfer - in/out car	Yes ❒No ❒	_____

Personal Care Needs

Continence	Yes ❒	No ❒	_____
Bowel Management	Yes ❒	No ❒	_____
Wash/ bathing	Yes ❒	No ❒	_____
Dressing	Yes ❒	No ❒	_____
Food Preparation	Yes ❒	No ❒	_____ _____
Eating & Drinking	Yes ❒	No ❒	_____
Bed Mobility	Yes ❒	No ❒	_____

Communication

Written	Yes ❒	No ❒	_____
Verbal	Yes ❒	No ❒	_____
Hearing	Yes ❒	No ❒	_____
Communication Aid	Yes ❒	No ❒	_____

Language

Irish Sign Language	Yes ❒	No ❒	_____
Non-native speaker	Yes ❒	No ❒	_____

Additional information in support of this application. Please include all relevant information

Referrer Check List

Does the applicant meet the criteria for ALS? Under 65 / Living South Lee/ Primary Physical Disability. If you are unsure, please call us 021 432 2651

PA Assisted Living Hours you are requesting / recommending _____

NOTE Hours are not guaranteed. The service may not be able to offer to level recommended. If the applicant is eligible, they will be contacted in writing and asked for their consent to be included in a prioritised waiting list. If you wish to be informed of the outcome of the LPC please include your e-mail address

Referred by:

Name: _____ Mob _____ e-mail _____

Signature of PHN _____ Date: _____

Signature Asst. D.P.H.N.: _____ Date: _____

Consent

This application has been fully explained to me and I consent to the referral being made to Cork Centre for Independent Living I understand that this information will be held on the HSE South database for the use of planning and providing Assisted Living /Home Support Services and on the database the Provider Agency. It will be kept in line with prevailing data protection guidelines and will be treated in strictest confidence. Copies of the HSE [www.hse.ie] & Cork CIL [www.corkcil.ie] General Privacy Policies are available on request or on the websites

Signed: _____ Date: __/____/____

Applicant / Parent / Guardian (tick ✓)

If you are signing on behalf of the applicant be sure you have their permission and please state your relationship to them _____

HSE – South South Lee Community Area / PHN Dept.

Physical & Sensory Disability Review Form

Modified Northwick Park Assessment *Date of Assessment ……. /……../……*	PHN Name_____ Mobile _____
Surname:_____ Forename:_____ Diagnosis_____	Address_____ D.O. B …. /……../……. Gender: Male ❒ Female ❒

For each item circle the highest score that applies and answer any additional questions.

1.	**Mobility**	0	**3.3**	**Frequency of emptying balder information only**						
a	Walks fully independent	1		During the day	4 times	5-6 times	>6 times			
b	Independent in electric / self-propelled chair	2		During the night	0 times	1 time	2 times	>2 times		
c	Walks with assistance supervision of one	3								
d	Uses attendant operated chair	4	**4**	**Urinary Incontinence**						
e	Bed-bound unable to sit in wheelchair	5	a	No accidents or leakages from catheter or convene						0
			b	Continent if toileted regularly. Occasional accident						1
2	**Bed Transfers**		c	1-2 episodes of incontinence/ leakage in 24 hours						2
a	Fully independent	0	d	>2 episodes of incontinence/ leakage in 24 hours						3
b	Requires help from one person	1	e	If scored 1 how many times per week					1 2 3 4 5 6	
c	Requires help from two people	2	f	If scored 3 how many times per week					1 2 3 4 5 6	
d	Requires hoisting by 1 and takes 1/2 hour	3								
e	Requires hoisting by 2 and takes 1/4 hour	3	**4**	**Toileting Bowels**						
			4.1	Need for Assistance						0
3	**Toileting and Bladder**		a	Able to empty bowels independently						1
3.1	Mode of emptying. Information only		b	Set up only e.g. give enema/ suppositories						2
	Which of the following does the service user use to empty their bladder?		c	Needs help/supervision from one and takes< 1/4 hr						3
	By Day	By Night	d	Needs help/supervision from one and takes >1/4 hr						4
	❒ Toilet	❒	e	Needs help/supervision from two and takes< 1/4 hr						5
	❒ Commode	❒								
	❒ Urinal	❒	**4.2**	**Frequency of Bowel Opening – Information only**						
	❒ Catheter/Convene	❒		❒ 2-3 times per week			❒ 4-5 times per week			
	❒ Continence Wear	❒		❒ Once a day			❒ Twice a day			
				❒ >twice a day			❒			
3.2	**Need for Assistance**									
a	Able to empty bladder independently	0		**What times of day do they normally open their bowels?**						
b	Set up only e.g. urinal left within reach	1		❒ Morning	❒ Mid-morning	❒ Midday				
c	Has indwelling catheter / convene	1		❒ Afternoon	❒ Evening	❒ Bed time				
d	Needs help/supervision from one and takes< 1/4 hr	2								
e	Needs help/supervision from one and takes >1/4 hr	3		**Do they need to open their bowels during the night?**						
f	Needs help/supervision from two and takes< 1/4 hr	4		0 times	1 time	2 times	>2 times			
			4.3	**Faecal incontinence**						