35 Langstone Way, Bittacy Hill,
Mill Hill East, London, NW7 1GT

Tel: 020 8371 6611
Fax: 020 8371 4225
Email: info@jbd.org
Reg. Charity No. 259480

DATE SENT
DATE RETURNED

Name			
Date of Birth		Marital Status	
PLACE OF BIRTH			
Permanent Address			
Email Address			
Phone Numbers			

If applying for joint accommodation:

Name of 2nd Applicant			
Date of Birth		Relationship to 1st Applicant	

Name of 3rd Applicant			
Date of Birth		Relationship to Applicants	

Present Address if different from above:

Present Address	
Phone Number	

If you were born outside the UK - How long have you lived here?	

Is your Accommodation: Owned [ ] Rented [ ] Sublet [ ] Tick where appropriate

Landlord's Name & Address

If you live in a flat, house or maisonette:

Are there stairs up to or in the property, number and location.

Which Floor | Is there a lift

How many: Bedrooms | Living rooms | Kitchens | Bathrooms | WC

Rent/Mortgage Payments

Do you Have Central Heating? **YES / NO**

Do you or your partner have any criminal convictions? **YES / NO**

Please give details and date of conviction.

Do you live alone **YES / NO**

If you do not live alone please state with whom you live and their relationship to you:

Do you have children **YES / NO** Number of Children

Please give the name, address and phone number for all of your children:
(Please use a separate sheet if you have more than 2 children)

NAME:

ADDRESS:

POSTCODE:

TEL NO.
HOME:

MOBILE:

WORK:

EMAIL ADDRESS:

NAME:

ADDRESS:

POSTCODE:

TEL NO.
HOME:

MOBILE:

WORK:

EMAIL ADDRESS:

Please give the name, home and email address and phone number for your Next of Kin and their relationship to you:

NAME:

ADDRESS:

POSTCODE:

TEL NO.
HOME:

MOBILE:

WORK:

EMAIL ADDRESS:

Please give the name, address and phone number for your Doctor:

Are you and your spouse Jewish: please tick the appropriate box:

Yes	No

You may be required to provide evidence and supporting documents.

Please give details of your Synagogue membership or Burial scheme:

Please give your Hebrew name:

Please give your reasons for needing re-housing, including any medical or social reasons:

Please list your disabilities and if they are deteriorating:

Are you registered as physically disabled? **YES / NO**
If not, could your be registered? **YES/ NO**
Do you have a blue badge? **YES / NO**
If yes, please give your registration number.
Are you registered blind or partially sighted? **YES / NO**

Independent living skills

Are you able to undertake the following task without assistance?

Bath/ shower **YES / NO**
Shopping **YES / NO**
Cooking **YES / NO**
Cleaning **YES / NO**

What, if any, domiciliary Homecare services and personal care (meals on wheels, home help, district nurse etc) do you receive and how often:

What is your National Insurance Number				
Do you hold a British Passport (please tick box)	Yes		No	
What is your passport number				

Financial Information (How much you would have to pay depends on your income and capital.) You will be asked to verify this information and sign a financial declaration.

Do you receive any of the following Benefits?

Benefit			
Income Support	**YES / NO**	Amount per week	
Housing Benefit	**YES / NO**	Amount per week	
Attendance Allowance	**YES / NO**	Amount per week	
Disability Living Allowance	**YES / NO**		
State Pension	**YES / NO**	Amount per week	
Pension Credit:	**YES / NO**	Amount per week	
Guaranteed	**YES / NO**		
Savings	**YES /NO**		
Private Pension	**YES / NO**	Amount per week	
Other disability allowance	**YES / NO**	Amount per week	
Additional Income	**YES / NO**	Amount per week	
Employ. & Support Allowance	**YES / NO**	Amount per week	
Job Seeker's Allowance	**YES / NO**	Amount per week	
Person Independence payment	**YES / NO**	Amount per week	

Do you or have you owned a property? **YES/NO**

If yes please provide full details of all the properties and including land.

Address:

Date Sold and Sale Price	**£**
Still owned: approx value	**£**

Employment **YES/NO**

Occupation	
Monthly Income	**£**
Hours worked	

Please give details of any Capital

Cash		Bank/Building Societies	
Policies		Shares/ Investments	
Other Assets			

Do you handle your own finances? **YES / NO**

If the answer is no, please provide below the name and address of the person that manages your finances on your behalf:

Do you have a Power of Attorney? **YES / NO**
Do you have Enduring / Lasting Power of Attorney? **YES / NO**
Is it registered? **YES / NO**

Please give details:

Have you applied to anyone else for re-housing? **YES / NO**

Please list local authorities and Housing Associations you have applied to for re-housing:

Area required

North East London ☐	Hertsmere & North West London ☐

Have you applied to Jewish Blind & Disabled before? If so, when?

Any further comments:

SIGNED DECLARATION

Please note that in the event of a tenancy being offered and taken up, where it is discovered that a tenant has deliberately given false information in their application for a tenancy, a County Court can make an order for possession of the dwelling on behalf of the Landlord under schedule 2 of the Housing Act 1985 and no alternative accommodation need be provided.

In order for your application to be considered, a medical questionnaire is required to be completed for each applicant by your doctor(s). We regret that we are not able to pay any fee which your doctor(s) might charge

The information contained on this form and in the attached medical questionnaire could be required for calculation of Housing Benefit or Universal Credit, or to assess if there has not been a deprivation of assets and I/we agree for this information to be made available to the relevant Local Authority or Government departments.

If I/we are successful in our application I/we understand that Jewish Blind & Disabled may ask for evidence of my finances and for additional information.

Signed		**Date**	
Signed		**Date**	

Do you give your permission for us to contact your current Landlord if necessary? Please sign below, giving your consent:-

Your signature:	**Date:**

Would your family members listed on this form be happy for JBD to contact them about the work of the charity? **They will have the opportunity to opt out if they wish to at a later date.**	**PLEASE CIRCLE BELOW AND SIGN**	
	YES	**NO**
	SIGNATURE:	

Additional information to support your application:

To whom it may concern:

I give my consent for you to provide my medical information to Jewish Blind & Disabled as part of my application for housing.

Please complete and return the attached form to me so that I can submit this information with my application form.

Thank you

Applicant Name

Applicant signature

Guidance to the medical professional completing the medical form:

Jewish Blind & Disabled is an independent charity that manages mobility apartments for applicants aged 18 upwards who have a physical disability and or vision impairment.

Our core philosophy is that every individual is entitled to a life of independence dignity and choice. Through our unique facilities we enable adults who are physically disabled or vision impaired to live independently.

By giving us as much information as possible we are then able to assess the application and ascertain if the applicant meets our criteria.

Please note that our buildings are not care homes but we do have on call house managers 24 /7 to offer support.

If you have any questions please call 0208 371 6611 option 2 where a member of the tenancy support team will assist you with your enquiry.

Medical Report for Tenancy Application 2018

(ONLY TO BE COMPLETED BY YOUR DOCTOR)

DATE SENT **DATE REC'D**

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Tel: **020 8371 6611**
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Reg. Charity No. 259480

Name of Applicant

Date of Birth

Address

When did you last see the patient? Date: ____________________

Do they have a disability as defined under the Equality Act 2010 **YES / NO**

Does their current home impact on their disability? **YES/NO/MAYBE**
Does the patient receive any Health Benefit Allowances (DLA/PiP) ? **YES/ NO / NOT SURE**

Please give details of disability and limitations they impose

YES / NO

Is the applicant registered as vision impaired? **YES / NO**

YES / NO

Please give details and limitations this imposes

Is there any mental disability? (including confusion/Alzheimer's or Dementia) **YES / NO**

Please give details

Is he/she known to have required psychiatric treatment? **YES / NO**

If YES, please give contact details of consultant and date of treatment

Is he/she subject to fits? **YES / NO**

Please give details

Is their disability chronic or deteriorating? **YES / NO**

Please give details

Does he/she require any form of personal or nursing care?	**YES / NO**

Please give details

Can he/she cook	**YES / NO**
Can he/she wash and dress self	**YES / NO**
Can he/she feed self	**YES / NO**
Can he/she walk unaided	**YES / NO**
Can he/she go up and down stairs	**YES / NO**
Can he/she get into a bath	**YES / NO**
Are any of the following used by applicant:	
Walking stick	**YES / NO**
Zimmer frame	**YES / NO**
Wheelchair	**YES / NO**
Bath seat	**YES / NO**
Has he/she been an in-patient at a hospital?	**YES / NO**

Why:

When:

Where:

Please attach a list of the patient's medication and treatments or detail this information below.

Please add any points not covered in the above.

In your opinion will the applicant be able to live independently within a sheltered environment for the next 5 years	**YES / NO**

Please imprint your Stamp below:

Signed:

Dated: