

# Transfer application form



## Important points

- Please answer all the questions in an honest and truthful way.
- Please write as clearly as you can in black ink
- This is a legal document, so please remember to sign the form

<b>How can we help you?</b> Please tick the box			
	<b>Mental Health</b>	<b>Learning Disability</b>	
Housing Service	<input type="checkbox"/>	<input type="checkbox"/>	
Support Service	<input type="checkbox"/>	<input type="checkbox"/>	

<b>About you</b> This should be completed by you or the person making the application for you									
Title:	First name:				Surname:				
National Insurance Number:									Date of Birth:
What is your Ethnicity?									
What Language do you speak?									
Do you need an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>									
<b>Do you use any of the following to communicate? Please tick the box</b>									
Spoken Word / Audio	<input type="checkbox"/>	Braille	<input type="checkbox"/>	Makaton	<input type="checkbox"/>				
Large Print	<input type="checkbox"/>	BLISS	<input type="checkbox"/>	Widget	<input type="checkbox"/>				

<b>Getting in touch</b>	
<b>How can we contact you?</b>	
Write your Telephone number here:	
Write your Mobile number here:	
Write your Email address here:	
<b>Your next of kin</b>	
Write their name here:	
Write their telephone number here:	
Write their address here:	

Your Social Worker or Care Manager	
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Write their name here:	
Write their telephone number here:	
Write their address here:	

Anyone else who we may need to contact	
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Write their name here:	
Write their telephone number here:	
Write their address here:	

Your current address		Address we should write to you (if different)	
Place name		Place name	
Number		Number	
Street		Street	
Town		Town	
County		County	
Postcode		Postcode	

<b>About you</b>			
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Are you (please tick the box)			
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Single	<input type="checkbox"/>	A single parent	<input type="checkbox"/>	A couple	<input type="checkbox"/>	A couple with children	<input type="checkbox"/>
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Please tell us about any other people who will be living with you	
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Their name:	
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Their address:	
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What is their relationship to you (eg partner, wife, husband, son, daughter)?	
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Their date of birth:	
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Please tell us about your finances and income	
Savings: if you have any savings please state how much	£
If you have a job, please give the name of your Employer	
Weekly income from your job before tax	£
Benefit	Amount per week
ESA	£
DLA ? PIP	£
Severe Disablement Allowance	£
Pension	£
Other income	£
Other	£
Other	£

Reason for Transfer			
Please tell us why you want to transfer to another property.			
Do you have any pets?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If you answered 'Yes', what kind of pet do you have?			

Section					
CPA	<input type="checkbox"/>	Supervised Discharge	<input type="checkbox"/>	Supervision Register	<input type="checkbox"/>
Section 117	<input type="checkbox"/>	Learning Difficulties Register	<input type="checkbox"/>	Sex Offenders Register	<input type="checkbox"/>
Care Management	<input type="checkbox"/>	Other Section	<input type="checkbox"/>		
Homelessness/ Threat of Homelessness					
Has no home	<input type="checkbox"/>	Eviction Notice	<input type="checkbox"/>	End of Assured Shorthold Tenancy	<input type="checkbox"/>
Leaving a Hostel	<input type="checkbox"/>	Leaving prison	<input type="checkbox"/>	Has to Leave Current Accommodation	<input type="checkbox"/>
Leaving Hospital	<input type="checkbox"/>	Leaving family to be more independent			<input type="checkbox"/>

<b>Unsuitable Accommodation</b>					
Lack of Amenities	<input type="checkbox"/>	Statutory Unfit	<input type="checkbox"/>	Poor Living Conditions e.g excessive damp, condensation	<input type="checkbox"/>
<b>Harassment</b>					
Domestic Violence	<input type="checkbox"/>	Racial Harassment	<input type="checkbox"/>	Other (Please Specify)	<input type="checkbox"/>

<b>What type of property do you want?</b>					
House	<input type="checkbox"/>	Bungalow	<input type="checkbox"/>	Shared house	<input type="checkbox"/>
Ground floor flat	<input type="checkbox"/>	Upper floor flat	<input type="checkbox"/>		
<b>Where would you prefer to live?</b>					
City	<input type="checkbox"/>	Country	<input type="checkbox"/>		
Do you already live in this area?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
If you answered 'No', why do you want to live here?					
Do you require disabled access?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Do you need 24 hour care/support?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	

**Data Protection Act 1998 Statement**

The information collected from this application is used in accordance with the Data Protection Act 1998. This information will be processed lawfully and fairly to ensure that applicants in housing and/or support need are identified and placed on the Housing/Support Register.

The information will be processed by Advance for monitoring our standard of service. We will hold information from this form on a computer system.

Any information shared with external agencies such as The National Register of Social Housing, Housing Corporation, Local Authorities, Department of Health and Social Care, is for reporting purposes and will not identify individual applicants.

<b>Your Declaration This must be signed by the person who wants to be put on the waiting list</b>	
I / We confirm that the information provided is correct to the best of my knowledge. I give my consent for Advance to hold this information about me, and agree to inform Advance of any changes to the details provided.	
I understand that if I knowingly give false information Advance will be entitled by law to take steps to terminate any agreement. I understand that Advance is entitled to make enquiries about my background.	
I authorise any former landlord, local authority, statutory or police authority, health or social care agency to disclose any relevant information in support of my application.	
Name: .....	Job Title: .....
Signature: .....	Date: ___ / ___ / ___

**This section to be completed by a medical or professional person**

**Assessment of support needs**

Medical history (please give details of any major operations and serious illness, including psychiatric treatment):

Does the applicant have a physical disability? (please give details):

Does the applicant use any special equipment or have there been any adaptations made to their home? (please give details):

Does the applicant have any allergies? (please give details):

Does the applicant have any fears or phobias? (please give details):

Medication / treatment received (please give details):

**Please indicate your assessment of the applicant's abilities and daily living skills using the following key for scoring in the assessment: (please tick as appropriate)**

**Key:**  
 1 = Fully competent / keen / interested    2 = Require some support    3 = Require considerable support    N/A

Skill	1	2	3	N/A
Ensuring security of home				
Operating household appliances				
Planning, preparing and cooking food, clearing up and putting away				
Maintaining hygiene, and day-to-day personal appearance				
Advice, prompting and reminding about a healthy lifestyle, i.e. taking medication				
Shopping				
Literacy & numeracy				
Budgeting				
Risk of exploitation				
Risk to self				
Risk to others				

**Declaration**

I / We confirm that the information provided is correct to the best of my knowledge. I / We understand this information is required before the individual can be placed on the waiting list for services.

Name: ..... Job Title: .....

Signature: ..... Date: \_\_\_ / \_\_\_ / \_\_\_\_

**Who is completing this application? (please tick as appropriate)**

Probation <input type="checkbox"/>	Local Authority <input type="checkbox"/>	Health and Social Care <input type="checkbox"/>
Other <input type="checkbox"/>		

Please tick the response that best fits your experience of the service  
 Excellent = above expectations Good = as expected Poor= below expectations

	<b>How would you rate the quality of the information you were given about applying for services?</b>	
	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Not Applicable <input type="checkbox"/>	
	<b>What additional information would have been helpful?</b>	
	<b>Did you understand all the information given?</b>	
	Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/>	
	<b>What did you find most difficult to understand?</b>	
	<b>Did you feel your application was handled promptly and were you kept informed about the process – how would you rate the service?</b>	
	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Not Applicable <input type="checkbox"/>	
	<b>Tell us about your experience?</b>	
	<b>Did you find Advance staff helpful and polite – how would you rate the service?</b>	
	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Not Applicable <input type="checkbox"/>	
	<b>Tell us about your experience?</b>	
	<b>Overall how would you rate application process?</b>	
	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Not Applicable <input type="checkbox"/>	
	<b>Do you have any compliments comments or suggestions to improve the service</b>	
	<b>Name</b>	
	<b>Signed</b>	<b>Date</b>