Carlow County Council

Social Housing Transfer Application Form

1. **Do I qualify to apply for a transfer?**

You must meet all the criteria listed below to qualify	**Yes**	**No**
I have lived in my tenancy for over 2 years		
I have a clear rent account and have enclosed 12 months rent history		
My dwelling is in satisfactory condition (provide photos of main living areas)		
I have complied with my tenancy agreement (if AHB tenant letter is required)		
I have no record of anti-social behaviour (if AHB tenant letter is required)		

If you ticked yes to all of the above, you are eligible to apply for a transfer. Please go to no. 2.

If you did not tick yes to all of the above, you are not eligible to apply for a transfer. Your application will not be considered and will be returned to you in full.

2. **Reason for Transfer**

Your reason for a transfer will only be considered if you meet at least 1 of the following.

Reason for Transfer	**Please tick all that apply**	**Submit these documents**
Overcrowding		Name and PPSN for all persons Proof of address
Rightsizing		Name and PPSN for all persons
Unsuitable accommodation		HMD Form 1 and Occupational Therapist report
Exceptional / compassionate		Relevant documents

If you ticked at least one of the above and can provide documentary evidence to support your reason your application for a transfer will be assessed and you will hear from us with a decision within 1 month of receipt of your application. The Housing Authority will verify all the documents you have submitted and where required look for more information.

If your application is successful you will be approved for a transfer.

All properties are allocated in line with the Council's Scheme of Letting Priorities which can be found on www.carlow.ie

Even where you are approved for a transfer, your eligibility for a transfer will be reassessed when a suitable property becomes available to check you still require the transfer.

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CARLOW COUNTY COUNCIL

CARLOW COUNTY COUNCIL

Transfer Application Form

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TRANSFER APPLICATION CHECKLIST

IMPORTANT

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

YOUR TRANSFER APPLICATION WILL NOT BE ACCEPTED IF IT IS NOT FULLY COMPLETED ON ALL SECTIONS, SIGNED, AND SUBMITTED TOGETHER WITH ALL RELEVANT SUPPORTING DOCUMENTATION AS FOLLOWS, WHERE APPLICABLE:

PPSN & Dates of Birth:		☐
Application form signed by Applicant(s):		☐
Income Details:	**Current payslips/social welfare slips** **Most recent P.60** **Most recent audited accounts if Self Employed** **Evidence of maintenance payable in respect of children**	☐
Medical:	**Enclosed HMD Form 1 to be completed by two medical practitioners where application is sought on medical grounds**	☐
Differential Rent Assessment Form:	**Enclosed Rent Assessment form to be completed fully For RAS and Carlow County Council tenants**	☐
Photo ID for applicants:		☐
Birth Certificates for all members of household:		☐
Court Orders:	**Maintenance/Custody/ etc.**	☐
Agreed Access:	**Where an applicant has included a child/children on the application and the children do not permanently reside with the applicant, and where no court/custody order is in place then an Affidavit signed by the child's/children's other parent is required**	☐

1. **MAKE SURE YOU HAVE ANSWERED ALL OF THE QUESTIONS FULLY WHERE THESE ARE RELEVANT TO YOU. IF YOU DO NOT THE FORM MAY BE RETURNED TO YOU.**

2. **BE SURE YOUR ANSWERS DO NOT GIVE FALSE OR MISLEADING INFORMATION. CARLOW LOCAL AUTHORITIES MAY REQUEST, AND OBTAIN INFORMATION FROM ANY HOUSING AUTHORITY, THE CRIMINAL ASSETS BUREAU, AN GARDA SIOCHANA, THE MINSTER FOR SOCIAL AND FAMILY AFFAIRS, A HEALTH SERVICE EXECUTIVE OR APPROVED VOLUNTARY HOUSING BODY IN RELATION TO OCCUPANTS OF, OR APPLICANTS FOR LOCAL AUTHORITY HOUSING. AND OF ANY OTHER PERSON THE AUTHORITY CONSIDERES MAY BE ENGAGED IN ANTI-SOCIAL BEHAVIOUR.**

3. PLEASE ENSURE THAT YOU HAVE SUPPLIED ALL THE RELEVANT INFORMATION AND SUPPORTING DOCUMENTATION TO PROCESS YOUR APPLICATION.

CARLOW COUNTY COUNCIL TRANSFER APPLICATION FORM

Tick whichever is appropriate:

CARLOW COUNTY COUNCIL TENANT ☐

OTHER LOCAL AUTHORITY ☐ **Authority Name _____**

RENTAL ACCOMMODATIONH SCHEME TENANT ☐

VOLUNTARY/CO-OPERATIVE TENANT ☐

ALL QUESTIONS MUST BE ANSWERED

SECTION 1 – APPLICANTS DETAILS

Applicant 1: _____

Address: _____
_____
_____
_____

Date of Birth: _____

Telephone: _____

PPSN: _____

Nationality: _____

Marital Status: _____

Applicant 2: _____

Address: _____
_____
_____
_____

Date of Birth: _____

Telephone: _____

PPSN: _____

Nationality: _____

Marital Status: _____

SECTION 2 – DETAILS OF ALL PERSONS INCLUDED IN APPLICATION

NAME	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	OCCUPATION	PPSN	WEEKLY INCOME	SCHOOL BEING ATTENDED

FAILURE TO SUBMIT PPSN FOR ALL PERSONS INCLUDED IN THIS APPLICATION WILL RESULT IN APPLICATION BEING RETURNED INCOMPLETE

N.B. EVIDENCE OF INCOME (P.60, PAYSLIP, LETTER FROM SOCIAL WELFARE) TO BE SUBMITTED

SECTION 3 – REASONS FOR REQUESTING TRANSFER

_____

_____

_____

_____

_____

_____

Area(s) of preference for housing: **1._____ 2._____ 3._____**

SECTION 4 – PRESENT ACCOMMODATION

Weekly rent if any being paid: **€_____** **Customer ID:_____**

Current method of payment:

Bank ☐

Household Budget ☐

County Council Office ☐

Other (give details) _____

Date of commencement of tenancy: _____

Any Arrears on Account: **Yes** ☐ **No** ☐ **Amount of Arrears:** _____

If yes, have you made an agreement to clear these arrears. Give details of agreement: _____

_____

Have you previously been transferred to alternative accommodation: **Yes** ☐ **No** ☐

How long have you resided at your present address: _____

What type of property are you living in now:

House ☐ **Flat** ☐ **Apartment** ☐

Total number of rooms: **Bedroom** ☐ **Bathrooms** ☐ **Kitchen** ☐ **Sitting Rooms** ☐

Living Rooms ☐ **Other** ☐

Type of heating: _____

SECTION 5 – ALL OTHER DETAILS

Are there any serious health problems in your household: _____
_____

If yes, please submit fully completed HMD Form 1.

Any other information you consider relevant: _____
_____
_____
_____
_____

NOTE: ANY INCOMPLE APPLICATION FORMS WILL BE RETURNED

APPLICANTS DECLARATION: This declaration must be read and signed by you.

A. **I am aware that if I give false or misleading information or omit to supply relevant information I may be excluded from being considered for housing.**
B. **I am aware that if included in the Council's housing needs assessment, I am obliged to notify the Council of any changes in circumstances which would affect my application. I undertake to notify the Council if I change address and I understand that if change of address is not notified to the Council my application for housing may not be considered.**
C. **I declare that the information as supplied on this form is to the best of my knowledge correct.**

(To be read as plural in the case of a joint application)

SIGNED: _____ **SIGNED:** _____

DATE: _____ **DATE:** _____

Completed application forms to be returned to:
Housing Department, Civic Offices, Tullow, Co. Carlow.

Housing Office,	**Phone: 059-9170300 - 9170367**
Carlow County Council,	**9170370 - 9136210**
Civic Offices,	
Tullow,	**Cottage No:**
Co. Carlow.	**Customer ID:**

Tenants: **Phone (H): _____**
Address: **(M): _____**

This Income Certificate must be completed in respect of ALL MEMBERS of the above household who are in receipt of an income. This is a two page document, please ensure to complete Page 2. PART A must be completed for all members who are employed (current payslips must be attached). PART B for all members in receipt of Social Welfare (current Social Welfare receipts must be attached). PART C MUST be completed by all tenants.

PART A – All Members of Household in Employment

Certificate of Income of Main/Highest Earner:

Name: _____ PPS No. _____

Gross Weekly Income (Excl. overtime & non-tax allowance) _____

Amount of PAYE deducted: _____

Amount of PRSI deducted (EE): _____

Amount of Income/Pension Levies/USC deducted: _____

Employer's Name & Address: _____

Employer's Signature: _____ Phone No: _____

Details of Others in Employment:

1. **Name: _____ PPS No: _____ Net Weekly Pay € _____**
2. **Name: _____ PPS No: _____ Net Weekly Pay € _____**
3. **Name: _____ PPS No: _____ Net Weekly Pay € _____**

PART B – All Members of Household in Receipt of SOCIAL WELFARE PAYMENTS

Name	Weekly Amount	U.B/U.A/Other Please Specify	PPS Number

Signature of Social Welfare Officer: _____ Date: _____

PART C

Particulars of all members of Household Tenant(s). Where children are over 16 years of age, please state if school going.

Name	Relationship to Applicant	Date of Birth	PPS Number

Any other information you consider relevant: _____
_____
_____
_____

N.B.

- **For those who are on FAS/Community Employment Schemes – please submit letter from your employer confirming same together with current payslip.**

- **Please tick the relevant box if you are/are not in receipt of maintenance YES___ NO___**
  If yes, evidence of maintenance received must be submitted.

Please note that this form cannot be accepted without evidence of income, i.e payslips, signature of Social Welfare Officer, etc. The local authority may request and obtain information from other bodies/agencies.

I DECLARE THAT THE FOREGOING PATRICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE (under Section 61 of the Housing Act, 1966, it is an offence to provide false information). Any person making a false declaration or who subsequently fails to notify any changes in circumstance are liable to maximum rent being imposed.

SIGNED: _____ DATE: _____
TENANT/JOINT TENANTS

HMD–Form 1

Disability and/or Medical Information Form

About this form

This form is for anyone who is applying for social housing or a social housing transfer **due to a disability or medical grounds.** The information provided will be used to assess if priority status should be awarded to an application.

What is priority status and who we give it to

When we give a person priority status on disability or medical grounds, this means they go **nearer to the top of the waiting list,** as set out in the Local Authority's Allocation Scheme.

Priority status may be awarded if the following three criteria apply to your household:

- you or someone in your household has a disability or a medical condition and
- the current accommodation is not suitable to meet the needs of the person with a disability or medical condition and
- a change in housing will improve or stabilise the circumstances of the person with a disability or medical condition.

Who needs to fill out and sign each section of this form

Section 1 and 2 to be filled out and signed by the person with a disability or medical condition or by the applicant for social housing support if the person with a disability or medical condition is a dependant of the applicant.

Section 3 and 4 to be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Other information

A Healthcare Professional includes the following professions: Consultant, General Practitioner (GP), Mental Health Nurse, Public Health Nurse, Occupational Therapist and Social Worker. If you are considering using a Healthcare Professional not listed above, please contact your Local Authority to confirm if this is acceptable.

An Occupational Therapist report **must be provided** where there is a need for a specific accommodation requirement.

If you require extra space to complete the form please include additional pages.

Section 1: Disability and/or Medical Information

This section must be filled out by the applicant.

Please tick (✓) the box to show the category you are applying under.

Disability grounds ☐ Medical grounds ☐

Please state your disability and/or medical condition

If you are a person with a disability, please tick (✓) which category of disability applies to you.

Physical ☐ Mental Health ☐ Intellectual ☐ Sensory ☐

Section 2: Personal Details

This section must be filled out as outlined on page 1. Please make sure the details you fill out here are the same as on your Social Housing Application Form.

Please fill in the details of the main housing applicant below.

First name

Surname

PPS number

Date of Birth

Declaration

I permit the Healthcare Professionals in Section 3 to give relevant medical details to the Local Authority to identify my housing needs.

Signature

Date

If the person with a disability or medical condition is not the main housing applicant, please fill in their details below.

First name

Surname

PPS number

Date of Birth

Section 3A: Medical Reference

This section must be filled out by two Healthcare Professionals (see page 1) who work with the person with a disability or medical condition.

Details of Healthcare Professionals completing this form

Healthcare Professional 1

First name

Surname

Name of organisation

Telephone

Email

Please indicate the professional service you provide to the person with a disability or medical condition.

Please tell us the total length of time the person with a disability or medical condition has been receiving your service.

One consultation only ☐ Weeks (number) ☐ Months (number) ☐ Years (number) ☐

Healthcare Professional 2

First name

Surname

Name of organisation

Telephone

Email

Please indicate the professional service you provide to the person with a disability or medical condition.

Please tell us the total length of time the person with a disability or medical condition has been receiving your service.

One consultation only ☐ Weeks (number) ☐ Months (number) ☐ Years (number) ☐

Section 3B: Applicant's Current Accommodation

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Is the person with a disability or medical conditions current accommodation directly or negatively affecting their disability or medical condition? If the answer is yes, please explain below.

Healthcare Professional 1

Healthcare Professional 2

Section 3C: Accommodation Need of Applicant

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

How would a change in location of accommodation benefit the person with a disability or medical condition?

Healthcare Professional 1

Healthcare Professional 2

What change in the type of accommodation would benefit the person with a disability or medical condition? and how?

Healthcare Professional 1

Healthcare Professional 2

What change in the design of accommodation would benefit the person with a disability or medical condition? and how?

Healthcare Professional 1

Healthcare Professional 2

Section 3D: Support Needs for the Applicant

This section must be filled out by two Healthcare Professionals who work with the person with a disability or medical condition.

Are supports currently needed to enable the person with a disability or medical condition to live independently? Please provide details.

Healthcare Professional 1 Yes ☐ No ☐

Healthcare Professional 2 Yes ☐ No ☐

Will the person with a disability or medical condition need any additional or new supports? Please provide details.

Healthcare Professional 1 Yes ☐ No ☐

Healthcare Professional 2 Yes ☐ No ☐

Section 4: Healthcare Professional Declaration

Healthcare Professional 1

I declare that the information and details I have provided on this form are correct and true.

I agree to the Local Authority contacting me, if necessary, to verify the details I have provided.

Signature	Date

Healthcare Professional 2

I declare that the information and details I have provided on this form are correct and true.

I agree to the Local Authority contacting me, if necessary, to verify the details I have provided.

Signature	Date

If you require extra space to complete the form please include additional pages.