MCCDW

APPLICATION BY COUNCIL TENANT FOR ADAPTATION WORKS TO FACILITATE IMPROVED MOBILITY / DISABILITY ACCESSIBLE ACCOMMODATION

Comhairle Contae Mhuineacháin

Monaghan County Council

Postal Address:
Housing Section
Monaghan County Council
The Glen
Monaghan

Telephone:
047 30500

Please Answer All Questions And Write Your Answers Clearly In BLOCK CAPITAL LETTERS

All Works MUST be APPROVED by MONAGHAN COUNTY COUNCIL who will arrange to have any NECESSARY works completed.

WORK MUST NOT BE UNDERTAKEN BY THE TENANT

MCCDW

Name: ______________________________

Address: ______________________________

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Date of Birth: ______________ PPS No: ______________

Telephone No: ______________ Mobile No: ______________

Name of person for whom the works are proposed (if different from above)

____

How long has he/she been living at this address: ______________

General Description of Works Required: ______________

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- **Please ensure that the attached Doctor's Certificate is completed, signed and Stamped by your GP and submitted with your application.**
- **Please also note that Monaghan County Council may, in some cases, request the HSE to provide an Occupational Therapy report.**

______________________ ______________________
Signature of Tenant Date

Completed application forms should be sent to:
Housing Section
Monaghan County Council
The Glen
Monaghan

DOCTOR'S CERTIFICATE

(Must be completed and submitted with your application)

I hereby certify that the proposed works on the attached application form are necessary for the accommodation of:

Name: ____

Address: ____

____

Who suffers from: ____________________________________

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Nature and Degree of Disability (Please tick as appropriate)

- Terminally ill or fully/mainly dependant on family or carer; or where alterations/adaptations would facilitate discharge from hospital or alleviate the need for hospitalisation in the future
- Mobile but needs assistance in accessing washing, toilet facilities, bedroom etc: or where without the alterations/adaptations the disabled person's ability to function independently would be hindered
- Independent but requires special facilities to improve the quality of life, e.g. separate bedroom/bathroom space
- If the proposed works include the provision of a Stairlift, please confirm your agreement that this is suitable and safe for use by the applicant

Name of Doctor: ______________________________________

Address: ____

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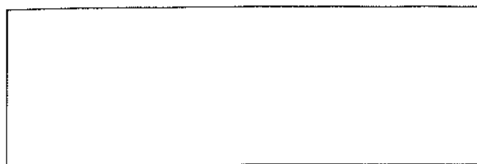
Doctor's Signature: ______________________ Date: ______________



Doctor's Official Stamp Here