

**HEALTH SERVICE EXECUTIVE – MID WEST REGION  
APPLICATION FOR HOME HELP SERVICE**

**NAME OF APPLICANT:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TEL. No.** \_\_\_\_\_ **MOBILE PHONE NO:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **PPS No.** \_\_\_\_\_ **GENDER male/female** \_\_\_\_\_

**STATE WHETHER MARRIED/SINGLE/WIDOWED/OTHER** \_\_\_\_\_

**Medical Card No.** \_\_\_\_\_ **G.P.** \_\_\_\_\_ **Tel No.** \_\_\_\_\_

**NEXT OF KIN:** \_\_\_\_\_ **Tel No.** \_\_\_\_\_ **Mobile No.** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**RELATIONSHIP TO APPLICANT:** \_\_\_\_\_

**LIVING ALONE: Yes/No** \_\_\_\_\_

**DETAILS OF PERSONS RESIDING WITH APPLICANT:**

NAME	DOB	RELATIONSHIP

**Health Status/Ongoing Health Needs:**

---

---

---

---

**Reason for requiring the service:**

---

---

---

**Signed by/on behalf of applicant** \_\_\_\_\_

**For Office Use Only:**

---

**APPROVED** \_\_\_\_\_ **REFUSED** \_\_\_\_\_

**WAITING LIST** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Please return completed application form to:**

**HOME HELP CO-ORDINATOR: St Mary's Health Centre, Parnell St, Thurles, Co Tipperary**

## CLIENTS SELF ASSESSMENT FOR PROVISION OF HOME HELP SERVICE

Tick boxes below that best describes your needs

### PERSONAL CARE

*Changing incontinence wear*

☐

*Assistance with washing/dressing/showering/bathing/washing hair/care of feet*

☐

*Assistance getting out of bed / back to bed / getting up and down stairs*

☐

*Assistance with feeding (excluding Peg Feeding, Nasal Gastric Feeding)*

☐

*Assistance to the toilet / commode / chair / wheelchair*

☐

*Assistance and supervision with walking within the home*

☐

*Changing bed linen and personal clothing*

☐

*Prompting the taking of medication as prescribed*

☐

### ESSENTIAL PRACTICAL CARE

*In special circumstances the following may be considered:*

*Ashes / Fire / Fuel*

☐

*Preparation of a full hot meal where there is no family or community catering*

☐

*Essential shopping*

☐

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_