

Self Referral Form

Please note: *All applicants must hold a current Community Services Card.
Housing NZ or City Council tenants are not eligible for this project.*

Date: _____

Applicant name: _____ Phone (Day): _____

Address: _____ Suburb: _____

Age of applicant: _____

Community Services Card number (the number on the back of your Super Gold card, not the client number):
_____ Expiry Date: _____

Number of people living in the residence: _____

Name and Age of other people in the household: _____

Which ethnic group do you belong to? (tick as many as apply)

- New Zealand European
- Māori
- Pacific Island
- Cook Island Maori
- Chinese
- Other such as *Dutch, Japanese, Korean* Please state: _____

Do you experience any of the following health conditions?

Health Condition	Severity of health condition		
	Mild	Moderate	Severe
<input type="checkbox"/> Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respiratory illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Circulation issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other, <i>please specify</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized for any of the above illnesses in the last twelve months?

- Yes _____ → How many times? _____
 No

Do you:

- Own your own home
- Rent from a private landlord (Housing NZ or City Council houses are not eligible for this project)

What is your weekly rental payment? _____

How many bedrooms in the home? _____

- Board with others (e.g. relative)

What is your weekly board payment? _____

How many bedrooms in the home? _____

Does the home owner have a Community Services Card? Yes No

If yes, what is their card number? _____ Expiry date: _____

If you **rent or board** with others please give the contact details of the house owner or property manager for the house that you are living in below.

Name: _____

Postal Address: _____

Phone Number: (Wk) _____ (Hm) _____

How long have you lived in the house? _____

How long do you intend to stay in your current residence? Less than 1 year Over 1 year

What is the approximate age of the house? _____

Does the house have any problems with (tick as many as apply):

- | | |
|--------------------------------|---|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Dampness or condensation |
| <input type="checkbox"/> Mould | <input type="checkbox"/> Draughts |

What kinds of heat sources are being used in the main living area? (tick as many as apply)

- | | |
|---|--|
| <input type="checkbox"/> Open Fire | <input type="checkbox"/> Coal burner |
| <input type="checkbox"/> Log burner/Pellet fire | <input type="checkbox"/> Unflued portable gas heater |
| <input type="checkbox"/> Heat pump | <input type="checkbox"/> Flued gas heater |
| <input type="checkbox"/> Fan heater | <input type="checkbox"/> Night store |
| <input type="checkbox"/> Bar heater | <input type="checkbox"/> Oil column heater |
| <input type="checkbox"/> Other (please state) _____ | |

Do you own any property, shares or investments? Yes No

If yes, what is the approximate value? _____

Do you require assistance or support from another person to complete the application and assessment process? (Optional) Yes No

Name of support person: _____ Relationship to applicant: _____

Contact details of support person (optional)

Postal Address: _____

Phone Number: (Wk) _____ (Hm) _____

Any other comments: (e.g. hearing problem etc): _____

How did you hear about the Elderly Health Project? _____

Signature: _____

Date: _____

Please Note: Community Energy Action cannot guarantee that any insulation or heating measures can be installed until after the house has been assessed. Acceptance on to the project is entirely at the discretion of CEA. All information supplied is confidential.

Post to: CEA (c/o Darci Westergard), P.O. Box 13759, Christchurch Or fax: (03) 363-9568