Home Sharing Scheme

Please attach a regular sized photograph of you and your family to the front of this form

CONFIDENTIAL HOST FAMILY APPLICATION FORM

PARTICULARS OF APPLICANT(S)

		Applicant 1	Applicant 2
(a)	Surname:		
(b)	Forename:		
(c)	Date of Birth:		
(d)	Address:		
(e)	Email:		
(f)	Telephone:		
(g)	Previous Address:		
	(Within the last 10 years)		
(h)	Occupation:		
(i)	Telephone Number(s):		

HOUSEHOLD COMPOSITION (PLEASE INCLUDE ALL MEMBERS OF THE HOUSEHOLD)

Name	Date of Birth	Occupation/School	Relationship to applicant

(a) Where did you hear about hosting a person with an intellectual disability?

(b) Whose idea was it to apply?

(c) Has the possibility of becoming a Home Sharing Family been discussed with the entire household?

Yes ☐ No ☐

(d) Please state the views of all the household members about applying to be a potential Home Sharing Family?

REFERENCES

Notes:

Applicant(s) should be well known to referees but should not be related.
Medical references are sought.
Garda Clearance is required.
Local Health Boards are contacted.

(a) REFEREES

(1)

Name: _____

Address: _____

_____

Telephone Number: _____

Occupation: _____

(2) Name: _____

Address: _____

_____

Telephone No.: _____

Occupation: _____

_____

(3) Name: _____

Address: _____

_____

Telephone No.: _____

Occupation: _____

_____

(b) Family Doctor

_____

Name: _____

Address: _____

_____

Note: Garda Vetting will be sought for every adult who resides at your address; Garda Vetting forms will be issued to you in due course.

Note: Social Work Departments are contacted in order to establish whether they have been in contact with your family and, if so, what is the context of this contact. If you have any queries surrounding this do not hesitate to contact this office.

CONSENTS

I, hereby give my consent to have confidential enquiries made by the Family Support Services concerning this application to the referees named above and to my family Doctor. I also give my consent to the Family Support Services to make confidential enquiries to the Gardaí and to the Health Board to establish the presence/absence of any child welfare/protection concerns.

Applicant 1

Signed: _____ Date: _____

Applicant 2:

Signed: _____ Date: _____

Please return completed application form to:

Sheelagh McInerney
Team Leader
Family Support Services
Fána Buí
Ballymoneen Road
Knocknacarra
Galway

091 515 410

or

Kieran Keon
Social Worker
Ability West
Blackrock House
Salthill
Galway

091 540 900