**RESTRICTED**

**Central Referral System for Rehabilitation Services**

**Subsystem for Elderly Persons with Visual Impairment**

**Application for Transfer to Other Residential Care Unit for Persons with Disabilities**

**Under Same Service Type**

|  |
| --- |
| Only person aged 60 or above and is certified as **blindness** or with **severe vision impairment** is eligible to apply for Care and Attention Home for the Aged Blind. |

|  |
| --- |
| Please use BLOCK LETTERS to fill in the information or give a ‘✓’ in the boxes, whichever is required. |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART A** | | | | **Applicant’s Personal Information** | | | | | | | | | | | | | | |
| 1. | Name of Applicant: | | |  | | |  | | | | | | | | ( ) | | |
|  |  | | | (In English, Surname first) (In Chinese) | | | | | | | | | | | | | |
|  |  | | |  | | |  | | | | | |  | | | | |
| 2. | HKID No.: | | | ( ) | | |  | | | | | | *or* | | | | |
|  |  | | | | | | | | | | | | | | |  | |
|  | Certificate of Exemption : L/M ( ) in RP 3/3/220/( ) | | | | | | | | | | | | | | | | |
| 3. | Date of Birth : | | |  | / |  | / |  | |  | | | | | | | |
|  |  | | | DD |  | MM |  | YYYY | |  | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | |
|  |  | | | | | | | | | | |  | | | | | |
| 4. | Sex:  Male  Female | | | | | | | | | | | | | | | | |
| 5. | Date of Admission: | | |  | / |  | / | |  | | |
|  |  | | | DD |  | MM |  | | YYYY | | |
| 6. | Name of Residential Unit : | | | |  | | | | | | | | | | | |
|  |  | | | |  | | | | | | | | | | | |
| 7. | Mobility: | | | | | | | | | | | | | | | | |
|  | Walk independently | | | | | | | | | | | | | | | | |
|  | Self-ambulatory with walking aid or wheelchair | | | | | | | | | | | | | | | | |
|  | Walk with escort | | | | | | | | | | | | | | | | |
|  | Chairbound / bedridden / paralysed | | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | | | | | | | | | |
| 8. | Mental State: | | | | | | | | | | | | | | | | |
|  | Normal / alert | | | | | | | | | |  | | | | | | |
|  | Disturbing / apathetic | | | | | | | | | | | | | | | | |
|  | Confused | | | | | | | | | | | | | | | | |
|  | Others (please specify): | | | | |  | | | | | | | |  | | | |
|  |  |  | | | | | | | | | | | | | | | |
| 9. | Incontinence: | | | | | | | | | | | | | | | | |
|  | Nil | | | | | | | | | | | | | | | | |
|  | Occasional urine or faecal soiling | | | | | | | | | | | | | | | | |
|  | Frequent urine or faecal soiling | | | | | | | | | | | | | | | | |
|  |  |  | | | | | | | | | | | | | | | |
| 10. | Welfare Assistance Currently Receiving: | | | | | | | | | | | | | | | | |
|  | Disability Allowance | | | | | | | | | | | | | | | | |
|  | Comprehensive Social Security Assistance | | | | | | | | | | | | | | | | |
|  | Old Age Allowance | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART B** | **Reason(s) of Application for Transfer** | | | | | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
| **PART C** | **Location Preference** | | | | | | | | |
|  | (Three parallel choices of home / district / region can be specified below. Please tick “No” if applicant does not have special location preference.) | | | | | | | | |
|  | No | | |  |  | | | | |
|  | Yes: Location preferences - | | | 1. |  | | | | |
|  |  | | | 2. |  | | | | |
|  |  | | | 3. |  | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
| **PART D** | **Source of Referral** | | | | | | | | |
|  | Referring Office: | |  | | | | | | |
|  | Referring Agency: | |  | | | | | | |
|  | Referrer: | |  | | | | | | |
|  | Address: | |  | | | | | | |
|  | File Ref. No.: | |  | | | |  | |  |
|  | Tel No.: | |  | | | | Fax No.: | |  |
|  | Signature: | |  | | | | Date: | |  |
|  |  | |  | | | |  | |  |
|  | Referrer has declared that there is no conflict of interest in handling this application. Referrer is not a family member or personal friend of the applicant and has no personal or social ties with the applicant, and she/he has notified the applicant/family member(s)/guardian/carer(s) that SWD and the referring agency will not charge for the application and referral for service. The applicant/family member(s)/guardian/carer(s) should report to the Independent Commission Against Corruption (ICAC) immediately in case anyone offers to assist in application for placement in return for remuneration. Attempted bribery by any person is also an offence in law, SWD will refer the case to ICAC for investigation.  **PART D** | | | | | | | | |
| **PART E** | **Endorsement**\* | | | | | | | | |
|  | Comment: |  | | | | | | | |
|  | Name: |  | | | | Signature: | |  | |
|  | Post Title: |  | | | | Date: | |  | |
|  | \*Endorsement should be obtained from agency head/designated representative of non-governmental organisation or DSWO/ADSWO of SWD. | | | | | | | | |
|  |  | | | | | | | | |