ASSESSMENT PACK FOR ALL GRANTS

AGENCY		**AGENCY WORKER**	
CLIENT NAME AND TITLE		**AGE AND DATE OF BIRTH**	
CC ID	**DATE OF FIRST ASSESSMENT/VISIT**		**DATE OF PLANNED REVIEW**		**PACK NO**	

Please tick all services the client is eligible for

HOME CARE	☐	**EMERGENCY FUND**	☐
AUSTRIAN FUND	☐	**CASE MANAGEMENT ONLY** *NO CC funding required*	☐

DIAGNOSTIC SCORE TOTAL	**Status Level**		**Maximum Hours on Status Level 1-3**	

Existing	New	**Care Level 1-6**		**Unmet Need Hours**	
LEVEL OF PFLEGEGELD RECEIVED		**CORRESPONDING NUMBER OF HOURS**	
NUMBER OF LA HOURS RECEIVED		**PROTECTED GRANDFATHER HOURS**	

A = Pflegegeld Hours		**B = AA Hours**		**C = LA Hours**		**D = Hours paid by Client**		**Net Government Hours A + B + C – D**	

ELIGIBLE FOR LA HOURS	YES	☐	REFERRED TO LA	YES	☐	OUTCOME	Pending	☐
	NO	☐		NO	☐		Refused	☐

Please record here the number of Homecare hours requested AFTER deducting GOVT hours received.

	EXISTING		ADDITIONAL/NEW		TOTAL	
	Hours	£	Hours	£	Hours	£
CLEANER/CHORES **Max 4 hrs**						
CARE						
TOTAL						

For Office Use Only	Checked		Date	
Approved by			Stamped and signed by Chairperson
Agency Medical for 10-40 hours	Date received		
MAF for 40-105 hours	Date received		
MAF 105 hours +	Date received		

PERSONAL INFORMATION

CLIENT SURNAME & TITLE	MARITAL STATUS	DATE OF BIRTH	AGE
FIRST AND MIDDLE NAMES	MAIDEN NAME	NAME AT BIRTH IF DIFFERENT	BIRTH CERTIFICATE SEEN
			YES ☐ NO ☐
ADDRESS	COUNTRY OF BIRTH TOWN OF BIRTH DATE OF ARRIVAL IN UK Day/Month/Year		
	TELEPHONE NUMBERS	NATIONAL INSURANCE NO	
		PREFERRED LANGUAGE	

Address if different from above	
Date of report Date/reason for Referral	

Present at visit	Name	Organisation/Address:	Telephone Number

Next of Kin Name	Address:	Telephone Number/ email

GP Name	Address	Telephone Number/ email

Agency Workers Name	Address	Telephone Number/ email
	AJR 3RD Floor Winston House 2 Dollis Park Finchley N3 1HF	

Other Agencies involved:		
Name:	Address/Organisation	Contact Person Tel /email

Contact details	Name	Address /Organisation
Key Holders		
Key Safe	☐YES ☐NO	
Life Line	☐YES ☐NO	

Synagogue/Burial Society member	☐YES	☐NO	Name of Synagogue	
Have you made a Will	☐YES	☐NO WHY NOT	Where/ Who has	
Do you have a Lasting Power of Attorney	☐YES	☐NO WHY NOT	Name of Attorney	

BACKGROUND HISTORY

Provide here a concise picture of the client's early family background including country and town and month and year of persecution. Type of experience - Camp Survivor, Hidden, Refugee, Ghetto Survivor, Slave Labour, Kindertransport, other. Also, list parents and siblings and describe their persecution. Please include details of any marriage and children, work and special interests.

COUNTRY OF BIRTH		TOWN		
WARTIME EXPERIENCE	From Year	To Year	Place	
Camp				
Slave Labourer				
Ghetto				
Hidden				
Living under false papers				
Refugee	Month		Year	
Kindertransport	Month		Year	
Add additional information here				

Client Signature		PRINT NAME	Date
Agency Worker's Signature			Date

MEDICAL INFORMATION - to be completed in conjunction with the Diagnostic Assessment	
PHYSICAL Health conditions Breathing Disabilities Communication Sensory Mobility/Foot Health Pain Weight Continence Consciousness Allergies/Skin Dental	
MENTAL HEALTH Mood Memory/Orientation Planning/Decision Making Behaviour/Aggression etc Other Mental Health Issues Relationship with others Mental Health Services Any history of psychiatric referral and outcomes	
MEDICATION Details Any difficulties Reviewed in last year	
ACCOMMODATION House Flat (Floor) Council/Homeowner Housing Association/ Sheltered Private Rented Level Access/Hazards Entry Phone/Key Safe Adaptations/Tele Care/ Life Line Smoke Alarm Heating Toilet/bathroom	
CARE ARRANGEMENTS **Informal/Private Carer** **Private Agency** **Cleaner** **Family** **Friends, Neighbours, Volunteers** **Frequency of contact** **Are you caring for another** **Day Centre** **Other Social Activities**	

LOCAL AUTHORITY – What involvement/assessment has been made by the Local Authority include here the number of hours and details of local authority care plans *AND ANY COST TO CLIENT*. Explain Care Package/Direct Payments/Personal Budget, NHS Funding. ***IF NO LA INVOLVEMENT EXPLAIN***

PFLEGEGELD – ATTACH SUPPORTING EVIDENCE FROM AUSTRIA

Level Awarded See attached Information		Corresponding No of Hours		If not in receipt date of application	
STATE WHY NO APPLICATION MADE					

ATTENDANCE ALLOWANCE MANDATORY See attached Chart	Higher Rate Corresponding No of Hours		Lower Rate Corresponding No of Hours		If not in receipt date of application
STATE WHY NO APPLICATION MADE					

CURRENT SITUATION/REASSESSMENT No		DATE	

Include Existing Diagnostic Score, New Diagnostic. Detail changes that have necessitated additional hours requested Use additional information sheet if required.

RECOMMENDATIONS – include here other relevant information about the client's needs

FINANCIAL SITUATION **An IAD and I&E must be attached to this pack on submission *OR IT WILL BE REJECTED.***	Give brief details of assets and income stating if client entitled to claim grants and list state benefits received. Also list documents seen as proof of income and eligibility.							
Documentary Proof of Income Status held on file by Agency.	***YES*** ☐	***IF NOT WHY NOT***						
IAD Completed for current year	***YES***	☐	***Date Completed***		***I&E Completed for current year***	***YES***	☐	***Date Completed***

BANK DETAILS FOR NEW CLIENTS ONLY – To be paid direct into their accounts once homecare claim form is received.

BANK NAME	ACCOUNT NAME		SORT CODE
ACCOUNT NUMBER		ROLL NUMBER (Building Societies Only)	

CLAIMS CONFERENCE IN-HOME SERVICES
NAZI VICTIM ELIGIBILITY ASSESSMENT FORM

Agency Name

Client ID No ***(if already provided by Claims Conference***

PRINT
Client's Full Name

The agency is responsible for verifying the identity of new clients by means of a UK NATIONAL Insurance No., a DWP letter and a government issued photo ID. Copies of which should be attached with this form to the Assessment Pack.

1. To assess the client's status as a Jewish Nazi victim in accordance with the German Government's definition prior to entering the client's data into Diamond, the agency must perform a due diligence review of the client's wartime persecution history and keep documentation in the client's file. The review must include determining whether the client has received funding from any of the below compensation programs. Attach evidence to pack.

☐Article 2 Fund	Claim No		☐BEG	Claim No	
☐Hardship Fund	Claim No.		☐ZRBG Ghetto Pension	Claim No	
☐Central & Eastern European Fund	Claim No.		☐Slave Labour Fund	Claim No	
☐Other (please specify)					

❖ If the client has not previously applied for individual compensation but the agency believes the client to be a Jewish Nazi Victim based on its due diligence review, the agency may enter the client's data into Diamond for further review by the Claims Conference. The client must complete the unified application form and submit it to the Claims Conference immediately. *For more information go to* http://www.claimsconorg/what-we-do/compensation/apply-for-compensation/. The information on the compensation form is necessary for the Claims Conference to research the client's wartime experience. If the client does not wish the application form to be submitted to Germany for compensation, please note this information at the top of the application form.

❖ If the client and/or the agency is unsure whether or not the client has previously applied for compensation, but the agency believes the client to be a Jewish Nazi victim based on its due diligence review, the agency may enter the client's data into Diamond for further review and await an update on the client's status from the Diamond automated email system. The client will not receive this information. It is the agency's responsibility to assist the client with any further action required by the automated email.

❖ In all cases, the agency must keep documentation of its due diligence review attached to this form in the client's file. The due diligence should include the name of any compensation the agency believes the client received, date of birth, place of birth and wartime experience as it relates to the Claims conference Jewish Nazi victim definition.

2. The following documentation must be obtained and attached to the file if the client is to meet the financial status eligibility criteria for the program. *Failure to demonstrate Jewish Nazi victim status or compliance with income and assets criteria will render clients ineligible for services funded by the Claims Conference, regardless of level of disability.*

☐ Client's declaration of income and assets.
☐ Documentary proof of client's income and assets – required for recipients of emergency assistance.
☐ Documentary proof that client is an Article 2 or CEEF recipient
☐ None – Client is not eligible for services*

**Exception clients receiving exclusively short-term case management or socialisation services may be served even if the do not meet the financial criteria, as noted in the Eligibility Guidelines under Financial statue.*

DECLARATION BY CLIENT I hereby agree that the information that I have provided to the Association of Jewish Refugees in Great Britain and the Claims Conference regarding my personal details and history is true and correct. In the event that the Claims Conference determines, according to its rules and procedures, that I do not meet the definition of a Jewish Nazi victim as defined by the Claims conference under the rules established by the German Government, I shall return to the Association of Jewish Refugees upon it is request the value of the social welfare services provided to me by the Social Welfare Agency with funds from the Claims Conference.

CLIENT'S SIGNATURE			DATE
Agency Worker's Name		**Agency Worker's Signature**	
Position		**Date**	
Reviewed by Name and Signature		**Position**	**Date**

ועידת התביעות
Claims Conference
The Conference on Jewish Material Claims Against Germany
www.claimscon.org

CLAIMS CONFERENCE DECLARATION OF INCOME AND ASSETS FOR ONGOING SOCIAL WELFARE SERVICES

Agency	**AJR**	Client Name and ID No	

Please complete this form promptly to confirm your eligibility for services under Claims Conference funding.

Claims conference funding is made available to Jewish Nazi victims who meet specific criteria and who are in financial need. Financial need is based both on the annual income and assets of the individual and therefore the information in the Declaration of Assets form is required. PLEASE NOTE that this form is not sufficient documentation of eligibility for Emergency Assistance Services.

Income refers to NET income after taxes have been deducted, including interest income on stocks or other investments. Government pensions, social security, retirement plan payments, company or employment pensions, disability or life insurance pensions, and BEG or Article 2 pensions are not counted towards income. Do not include your spouses's income.

Assets include, amongst other items: cash in the bank, the value of stocks/shares and any property you own or the paid-up value of a life insurance policy. Only 'net assets' are relevant, i.e the value of the property less the value of any debts, mortgages or annual tax on or related to the property.

DO NOT INCLUDE THE VALUE OF THE SINGLE/PRIMARY PROPERTY IN WHICH YOU RESIDE.

IF ANY ASSET IS JOINTLY OWNED BY YOU AND YOUR SPOUSE, INCLUDE ONLY HALF THE VALUE AS YOUR OWN.

I,	Name		
	residing at		*Declare my income and assets to be as stated below:*
My Net Income and Net assets as explained above are:			Income £ Assets £

I FURTHER DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE ABOVE INFORMATION GIVEN IN THIS FORM IS TRUE AND CORRECT, AND THAT ANY FALSE STATEMENT WILL RESULT IN THE DISCONTINUATION OF SERVICES AND FURTHER LEGAL CONSEQUENCES.

Signed		Date	

Guide only – use I & E on A Forms

FINANCIAL INFORMATION - INCOME AND EXPENDITURE					
CLIENT NAME			**AGENCY WORKER**		
DATE INFORMATION OBTAINED			**NI NO.**		
INCOME	**WEEKLY**		**EXPENDITURE**	**WEEKLY**	
	SELF	**SPOUSE**		**SELF**	**SPOUSE**
Earnings from any employment			Mortgage		
Rent and property income			Rent/Board/lodgings		
Interest from Savings			Service Charges		
Income from investments			Supporting People Services		
Income from other Charities			Ground Rent		
List them			Insurance - Buildings		
			Insurance - Contents		
			Council Tax		
			Water Rates		
AJR Self Aid			Electricity		
Other Income			Gas		
			Telephone/Internet/Mobile		
			TV Rental/Licence/Cable		
			Call Alarm		
Sub Total (net) Income	**0**	**0**	Property Maintenance		
Pensions and Benefits			Gardener		
State Retirement Pension			Cleaner		
Pension Credit			Food/Extra dietary needs		
Housing Benefit			Meals on Wheels		
Income Support			Household Items		
Attendance Allowance - Lower			Laundry/Dry Cleaning		
Attendance Allowance - Higher			Non Prescription Items		
ESA			Health Cover		
PIP			Optician		
Other			Dentist		
			Physiotherapy		
			Chiropody		
Occupational Pension			Clothing		
German Compensation Pension			Hairdresser		
Austrian Compensation Pension			Nurse/Home Care		
Other Holocaust Related Pension			Day Centre		
Any Other Pension			Synagogue Fees		
			Car Expenses		
			Newspapers/Postage		
Other			Travel Expenses/Taxis		
Home Care Claims Conference			Boiler/Heating Cover		
Other Claims Conference			Social		
Any Other Income			Other		

Remember to list assets!

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Claims Conference
The Conference on Jewish Material Claims Against Germany
www.claimscon.org

CONSENT FORM

In order for Association of Jewish Refugees in Great Britain to be able to assess your eligibility for grant assistance under this and other programs, we have asked you to provide detailed personal information about yourself, your financial position, your medical condition and your Nazi persecution, (we refer to this as 'Personal Data'). This information, gathered with the assistance of your designated staff member, is necessary to determine your eligibility for services in accordance with the grant guidelines of the Conference on Jewish Material Claims against Germany, Inc. ('Claims Conference').

How do we use your Personal Data?
Association of Jewish Refugees in Great Britain uses the information you provide to assess whether you qualify for benefits under the grants and benefits programs of the Claims Conference. We will also keep records about the services and benefits which we provide to you through Claims Conference funding. We have a legal obligation under the data protection laws to keep your Personal Data safe and secure to the best of our knowledge and belief.

Passing Personal Data to others
It is a pre-condition of the funding that both the funders (such as the German Government and the Austrian Government) and the Claims Conference receive copies of the Personal Data of all grant recipients, to enable each of them independently to monitor and review your eligibility under the programs. Thus, Association of Jewish Refugees in Great Britain will be obliged to pass copies of your Personal Data to the Claims Conference and, directly and/or through the Claims Conference, to the funders. The Claims Conference and the funders have a legal obligation to ensure to the best of their knowledge and belief that your Personal Data will be held securely and only used for the purpose of monitoring and review of awards made under the programs.

External Verification
In order to verify your eligibility under the programs, the Claims Conference (and its authorized representatives) may check your Personal Data against relevant files relating to your persecution history held by governmental agencies, courts, archives and institutions in Germany or elsewhere. By signing below, you will also be providing your authority for the Claims Conference to undertake this review.

I confirm that I have read and understood the above and consent to its terms.

Name of Individual		Signed		Date	
CONFIRMATION					
Agency		Agency Worker's Name		Date	

ADDITIONAL INFORMATION

AJR The Association of Jewish Refugees	*Return to* AJR 3RD Floor Winston House 2 Dollis Park, Finchley N3 1HF Tel: 0208 385 3070	ALLOCATED WORKER DIRECT TEL:

MEDICAL FORM (CONFIDENTIAL)
(For completion by General or Hospital Practitioner if applicable)
A comprehensive assessment is being undertaken on the patient named below to identify their health and care needs. This medical history is required to ensure your patient receives the appropriate assistance to meet his/her needs within the community or in a care home setting.

PATIENT'S DETAILS

SURNAME	**DATE OF BIRTH**	**ADDRESS**
OTHER NAMES	**NHS NO**	**TEL**

My medical information is required as evidence of my medical needs. I give permission for the requested medical information to be given to my Agency Worker.

SIGNATURE DATE

TO BE COMPLETED BY GENERAL/HOSPITAL PRACTITIONER

NAME	ADDRESS	TEL: FAX:

DIAGNOSIS Please list any known current acute and chronic conditions					
DIABETES	Diet Control ❑	Tablets ❑	Insulin ❑		
PAST MEDICAL HISTORY Please list any past acute and chronic conditions	*If the applicant has been seen by a consultant geriatrician please give name and details and attach copies of relevant reports.*				
CURRENT DRUGS Please detail the conditions these drugs are prescribed for	*List Medication or attach medication prescription sheet*			Self Medicating Needs Help	❑ ❑
PNEUMOCOCCAL VACCINATION	YES	❑	No ❑	Date	

SENSITIVITIES/ ALLERGIES (GIVE DETAILS)	DRUGS ❑ FOOD ❑ OTHER ❑	
DOES THE PATIENT HAVE A DIAGNOSIS OF DEMENTIA? Please specify type and comment on how this impacts on the patient's behaviour and ability/inability to self-care.	Yes ❑ No ❑ ***Please attach latest psycho-geriatrician's report.***	Name of Consultant and Tel No
	Alzheimer's ❑ Vascular ❑ Lewi Body ❑ Other ❑ Date of diagnosis Last reviewed Comment	
Does the patient have a history of confusion, cognitive impairment and/or short-term memory loss?	Yes ❑ No ❑ Comment	
PLEASE INDICATE ANY HISTORY OF MENTAL HEALTH including Depression or Anxiety. Alcohol/drugs misuse). Please give details		
PLEASE INDICATE ANY ISSUES RE CONTINENCE/ MANAGEMENT **(catheter/stoma or use of aids/pads).**		
SENSORY IMPAIRMENT **Please indicate any impairment in vision/hearing, or conditions such as Glaucoma etc.**		

If the applicant is in hospital at present, give Name of Hospital and Reason for Admission and length of stay.

Date patient last seen by you:

SIGNATURE OF DOCTOR	PRINT NAME	DATE

CONSENT FORM
ARTICLE II AND HARDSHIP FUND

CLAIM NO	FIRST NAME	LAST NAME

NB: IF YOU HAVE ALREADY SUBMITTED A POWER OF ATTORNEY TO THE CLAIMS CONFERENCE BY ATTACHING IT TO YOUR APPLICATION FORM, YOU DO NOT NEED TO COMPLETE THIS FORM. IF YOU MAILED THE POWER OF ATTORNEY SEPARATELY, PLEASE COMPLETE THIS FORM.

I	
NAME OF APPLICANT	RESIDING AT THE ABOVE ADDRESS
TELEPHONE NO	

HEREBY AUTHORISE THE AJR TO MAKE ENQUIRIES REGARDING THE ABOVE FUNDS.

Signed		Date	

GUIDELINES

To assist with completing the Background History on Page 3 and the Nazi Victim Eligibility Assessment Form on Page 10 please consult these guidelines:

Fund name	Amount	Payment type	Features/Comment
Article 2 Fund	€291 (approx. £245)	Monthly	Paid quarterly by Claims Conference office in Frankfurt
Hardship Fund	€2,556 (approx. £2,150)	One-time	Paid by Claims Conference office in Frankfurt. Hardship refers to having missed earlier opportunities to claim compensation, not financial need
Central & Eastern European Fund	€240 (approx. £200)	Monthly	In the main this is not relevant to us as it applies to residents of countries in Central and Eastern Europe (Former Soviet Union). However, some survivors from there who moved here may be receiving it; they can apply to be 'upgraded' to the Article 2 Fund
Slave Labour Fund	DM 15,000 (at the time it was paid this equated to approx. £4,600). It was paid in two instalments: £3,100 then around 18 months later £1,500 (subject to exchange rates)	One-time	Paid by the German Foundation: Remembrance, Responsibility and Future. Recipients also automatically received a top-up payment from the Swiss Banks Settlement. This was also paid in two instalments totalling $1,450 (£1,000 at that time)
Budapest Fund	€1,900 (approx. £1,600)	One-time	As well as other restrictions, the payment is reserved for Nazi victims from Budapest who currently reside in any of the former communist-bloc countries of Eastern Europe or the former Soviet Union
BEG (German compensation pension)	Varies but typically £300-400	Monthly	Paid, in the main, to ghetto and concentration camp survivors since the 1950/60s.

CLAIMS CONFERENCE NAZI VICTIM STATUS ***Updated 2016 (Excluding Austrian Fund)***

A Nazi victim is considered to be any Jew who has lived in Germany, Austria or any other country occupied by the Nazis or their Axis allies or who emigrated from any of the countries below after the following dates and before liberation and suffered recognised persecution.

Germany – between 30 January 1933 and May 1945
Austria – between July 1936 and May 1945
Czechoslovakia – between October 1938 and liberation in May 1945
Poland – between 1 September 1939 and liberation in January 1945
(NOTE: the city of Lvov (also known as Lemberg,) formerly in Poland and now Ukraine was liberated in July 1944)
Algeria – between July 1940 and November 1942 (for those who were in recognised camps only.
Tunisia – between July 1940 and May 1943
Morocco – between July 1940 and November 1942 those in Spanish Morocco and Tangiers are not eligible.
Denmark – between April 1940 and May 1945
Norway – between April 1940 and May 1945
Belgium – between May 1940 and February 1945
Netherlands – between May 1940 and liberation in May 1945
France – between May 1940 and liberation in September 1944
Luxembourg – between May 1940 and February 1945
Hungary – between April 1941 and liberation in Budapest in January 1945 (certain parts of Western Hungary were liberated in March 1945)
Yugoslavia – between April 1941 and liberation in May 1945
Greece – between April 1941 and November 1944 (liberation of some islands such as Rhodes was in May 1945)

Libya – between February 1941 and February 1943
Albania – between September 1943 and November 1944Italy – between 9 September 1943 and liberation in April 1945 *(NB Rome was liberated in June 1944 and more southern parts of Italy even earlier)*
Bulgaria – between April 1941 and September 1944
Romania – between April 1941 and August 1944 (NB Hungarian occupied Transylvania eg Satu Mare was liberated in October 1944)
Dutch East Indies – between November 1943 and May 1945
Former Soviet Union-occupied Western areas, which include:

- Northern Caucasus between August 1942 and February 1943
- Pskov Region, Russia between July 1941 and July 1944
- Latvia and Lithuania between June 1941 and October 1944 (Kurland in Latvia was liberated in May 1945)
- Estonia between June 1941 and October 1944
- Belarus between June 1941 and July 1944
- Moldova between June 1941 and April 1944
- Ukraine between June 1941 and liberation in March 1944 (although the Eastern part of Ukraine was liberated earlier such as Kiev in November 1943) the former Polish parts of Galicia were liberated later in summer 1944 eg Lviv in July 1944 and the former Czechoslovakian Karpato-Ukraine was liberated in October 1944
- Leningrad/St Petersburg between June 1941 and January 1944

In addition, Jews, who survived the Leningrad siege, are eligible.
Jews who fled between 22 June 1941 and 27 January 1944 from areas of the Soviet Union up to 100 km from the most easterly advance of the German Army (Wehrmacht) but were not later occupied by the Nazis. This covers cities such s Moscow and Stalingrad.
Jews born in Shanghai between February 1933 and May 1945 with parents that fled from Nazi Germany or their Axis allies.
Foetus cases – ie persons who were in utero at the time their mother were persecuted. The Nazi victims' mother must meet the above criteria.

In cases were Nazi victim status is unclear, agencies should consult the Claims Conference who will refer the matter to an in-house expert for clarification.

SECTION B

FOR AJR USE ONLY

RISK ASSESSMENT FORM

Agency Worker's Name		Date of Assessment	
Name/Address/Tel No of Client			
Next of Kin & Tel No.			
Name & Tel No of GP			
AREA		Notes	
Can you park nearby?	**YES** ☐ **NO** ☐		
Are there any timed parking restrictions?	**YES** ☐ **NO** ☐		
Is there suitable lighting?	**YES** ☐ **NO** ☐		
THE HOME		Notes	
Description of Property House/Flat/Owner/Tenant			
Entry phone system?	**YES** ☐ **NO** ☐		
Is there easy access to the front door?	**YES** ☐ **NO** ☐		
Is there an appropriate room to meet in?	**YES** ☐ **NO** ☐		
Is the home clean?	**YES** ☐ **NO** ☐		
Are there suitable chairs to sit on?	**YES** ☐ **NO** ☐		
Is the lighting adequate?	**YES** ☐ **NO** ☐		
Would you have a glass of water there?	**YES** ☐ **NO** ☐		
Are there any obvious health and safety hazards? wires, threadbare carpets, nasty smells, adequate heating, animals, toilet	**YES** ☐ **NO** ☐		
THE CLIENT		Notes	
Is the client positive towards visit?	**YES** ☐ **NO** ☐		
Is the client clean?	**YES** ☐ **NO** ☐		
Is the client dressed?	**YES** ☐ **NO** ☐		
Is the client showing signs of confusion	**YES** ☐ **NO** ☐		
Is the client showing signs of depression?	**YES** ☐ **NO** ☐		
Is the client showing signs of physical illness?	**YES** ☐ **NO** ☐		
Is the client likely to be aggressive or physically/verbally abusive?	**YES** ☐ **NO** ☐		
Is there anybody else living there who may be physically/verbally abusive?	**YES** ☐ **NO** ☐		
Does the client live alone?	**YES** ☐ **NO** ☐		
Does the client have a lifeline?	**YES** ☐ **NO** ☐		
Does the next-of-kin have objection to their details being shared?	**YES** ☐ **NO** ☐		

AJR The Association of Jewish Refugees

MEALS-ON-WHEELS ASSESSMENT FORM

Agency Worker		**Date**	
Client Name		**Next of Kin/Relationship**	
Address		**Contact Details**	
Tel No			

Member of AJR	**Yes** ☐	**No** ☐	**Date of Birth**		**Place of Birth**	

Able to stand alone	☐ **Yes**	☐ **No**	Rheumatism – Fingers/Hands	☐ **Yes**	☐ **No**
Can walk unaided	☐ **Yes**	☐ **No**	Arthritis – Fingers/Hands	☐ **Yes**	☐ **No**
Can walk with Zimmer frame	☐ **Yes**	☐ **No**	Able to use Hands	☐ **Yes**	☐ **No**
Wheelchair bound	☐ **Yes**	☐ **No**	**HAS A LIFELINE**	☐ **Yes**	☐ **No**
Housebound	☐ **Yes**	☐ **No**	**WHO DOES SHOPPING?**		
Hard of hearing	☐ **Yes**	☐ **No**	Self	☐ **Yes**	☐ **No**
Wears hearing aids	☐ **Yes**	☐ **No**	Neighbour	☐ **Yes**	☐ **No**
Registered Blind	☐ **Yes**	☐ **No**	Other	☐ **Yes**	☐ **No**
Registered Partially Sighted	☐ **Yes**	☐ **No**			

COMMENTS

COOKING FACILITIES

Microwave ☐	**Electric** ☐	**Gas** ☐	**SIZE OF FREEZER**

SPECIAL DIET REQUIRED	
ACCOMMODATION AND ENVIRONMENT	
OTHER ASSISTANCE NEEDED	
ANY OTHER INFORMATION	

AJR The Association of Jewish Refugees		**VOLUNTEERS' DEPARTMENT REQUEST FORM**	
Date		**Agency Worker's Name**	
Client Name & Title		**Date of Birth**	
Address		**Tel No**	
Country of Persecution		**Emergency Contact – Name Address & Tel No**	
Next of Kin Name		**Address & Tel No**	
GP		**Tel No**	

Is the client in Agreement for a volunteer visitor	Yes	☐	No	☐
Description of client's situation (including family situation) and reason for referral				
Previous occupation and interests				
Is the Risk Assessment Form attached?	Yes	☐	No	☐

CHECK LIST - REQUIRED PAGES FOR PACKS

ASSESSMENT PACK

P 1	Front Cover	☐	MAF for 105 hours +	☐
P 2	Personal Information	☐	CC Pension one Time Payment Hardship Form *or proof of eligibility*	☐
P 3	Background Information	☐	Consent Form Article 11 and Hardship Fund	☐
P 4	Physical – Care Arrangements	☐	Photo ID	☐
P 5	All Government Hours – Bank Details	☐	DWP Letter	☐
Ps 6-9	4 pages CC DAF Excel Document	☐	Additional Information Page *(Optional)*	☐
P 10	CC Nazi Victim Eligibility Assessment Form	☐	Guidelines	
P 11	CC Income and Assets Declaration	☐		
P 12	Income and Expenditure Form	☐	**Section B for AJR USE ONLY**	
P 13	CC Consent Form	☐	Risk Assessment	☐
	Medical for 10-40 hours	☐	Meals on Wheels	☐
	MAF for 40-105 hours	☐	Volunteer Request Form	☐

REVIEW PACK

P 1	Front Cover	☐	P 11	Updated CC Income and Assets Declaration	☐
P 2	Personal Information	☐	P 12	Updated Income and Expenditure Form	☐
P 3	NOT REQUIRED	☐	P13	NOT REQUIRED	
P 4	Physical – Care Arrangements	☐		Medical for 10-40 hours ***If not obtained previously***	☐
P 5	All Government Hours – Bank Details	☐		MAF for 40-105 hours ***If not obtained previously***	☐
Ps 6-9	4 pages CC DAF Excel Document	☐		MAF for 105 + ***If not obtained previously***	☐
P 10	NOT REQUIRED			Additional Information Page *(Optional)*	☐

Example of Calculation A + B + C - D

A Pflegegeld Hours = 5.75	B AA Hours = 3	C LA Hours = 10	D Hours paid by Client = 2	A + B +C - D Net Government Hours = 16.75

ADDITIONAL INFORMATION

1. Everyone must have completed a Hardship Form or be in receipt of compensation to enable them to receive a Diamond Number and qualify for Homecare Funding. Hardship Form must be attached to First Assessment pack on submission.
2. Everyone must be in receipt of in the process of applying for English Attendance Allowance. Copy must be attached to file
3. All Austrians must be in receipt or in the process of applying for Pflegegeld.

STATUS 3	Jewish Nazi Victims who suffered persecution in French Morocco (forced residence or curfew) may receive up to 25 hours per week of home care (homecare Approval Status 3 in Diamond).
STATUS 2	Jewish Nazi Victims who suffered persecution (except those in Morocco and described above) may receive up to 40 hours per week of homecare (Homecare Approval Status 2 in Diamond).
STATUS 1	Jewish Nazi Victims, who were in a concentration camp, ghetto or lived in hiding or false identity for at least six months, can receive up to 168 hours of home care per week (client must be Homecare Approval Status 1 in Diamond. For clients residing in Eastern Europe or the former Soviet Union, there is no limit of home care hours based on persecution experience and they may receive up to 168 hours of home care per week.

Score - Hours/week table	Total Numeric Score:	Score - Hours/week table	Total Numeric Score:
Care Level 1	3.25 - 4.50	Care Level 4	25.25 - 35.00
Care Level 2	4.75 - 10.75	Care Level 5	35.25 - 45.00
Care Level 3	11.00 - 25.00	Care Level 6	45.25 - 69.50

ATTENDANCE ALLOWANCE/PFLEGEGELD EQUIVALENT HOURS FOR DEDUCTION

See below corresponding to rate per hour that client pays

Private Agency Local Rates		Band 1 up to £11 per hour	Band 2 £12-13 per hour		Band 3 £14 to £16 per hour			Band 4 £17-£18 per hour		Band 5 £19-£20 per hour		Band 6 £21-£22 per hour	
£		11	12	13	14	15	16	17	18	19	20	21	22
Lower Rate	55.65												
Hours deducted		5.25	4.75	4.50	4	3.75	3.50	3.50	3.25	3	3	2.75	2.75
Higher Rate	83.10												
Hours	deducted	7.75	7	6.50	6	5.75	5.25	5	4.75	4.50	4.25	4	4