

MEDICAL ASSESSMENT FORM



REF NO:

NAME:

ADDRESS:

FORM SUPPLIED BY:

If you need help in completing this form, or accessing the scheme, please contact us and tell us what we can do to help.

Please tick the box which applies to you:

I am an applicant who has a medical/welfare need and I have not already provided information on my medical/welfare needs.	<input type="checkbox"/>
I am an applicant who has already submitted information on my medical/welfare need and am requesting a re-assessment as my circumstances have now changed/deteriorated	<input type="checkbox"/>

MEDICAL INFORMATION

Please ensure that you give all information that you feel is relevant as only the information you provide will be used in our assessment. This may include letters from your GP or specialist for example.

Please complete the following section for **each person** on this application (including yourself) that has a medical illness or disability that affects their housing needs:

	Person 1	Person 2	Person 3
Name			
Date of Birth			
Please briefly describe the physical or mental health conditions, including mobility, sensory and learning issues			
Name, address and telephone of doctor, specialist, consultant or any other specialists or care givers involved. (Such as Occupational Therapist, CPN, Social Worker, friend or relative etc.)			



Please list any medication prescribed			
Please describe how current home makes medical or mental health conditions worse			

Please continue on a separate sheet if necessary

Do you or anyone to be rehoused with you use a wheelchair?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please specify whether All the time, Occasional or Outdoor only:		

Do you or anyone to be rehoused with you use a walking aid? For example, stick, crutches, frame, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please specify whether All the time, Occasional or Outdoor only:		

Are you or anyone to be rehoused with you in receipt of Attendance Allowance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please specify whether High or Low rate:		

Are you or anyone to be rehoused with you in receipt of Disability Living Allowance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please specify whether High or Low rate:		

For medical reasons do you or a person to be rehoused with you sleep in a room which is not a bedroom?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please give details:		

Are you or anyone to be housed with you Registered Disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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What bathing and toilet facilities are available in your current home?

Downstairs Bathroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Upstairs Bathroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Downstairs Toilet	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Upstairs Toilet	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Outside Toilet	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Has your current home been adapted?

Ramp/level access	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stair Lift	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Level Access Shower	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Downstairs bedroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Additional wheelchair access (for example widened doors, toilets, grab rails, kitchens etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other (please state)		
Will any of the above adaptations be required on rehousing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please specify		
Would you be able to stay in your own home if it was adapted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Mobility

Please put the names of relevant people (including yourself) with mobility issues to be rehoused with you in the appropriate boxes below:

Ability to manage	With ease	With difficulty	With significant difficulty	With support adaptations	Not able to manage
Stairs/steps inside your current home					
Stairs/steps outside your current home					
Able to access and use current toilet facilities					
Able to access and use current bathing facilities					

Welfare

Do you need to be rehoused in order to provide or receive care/support from family or friends? Yes No

If yes please give details:
(For example: Who do you need to assist or receive assistance from? Where do they live? Why do you need to provide/receive support from this person?)

If there are any other reasons your current accommodation has a detrimental effect on your health or well-being and relocating to a different property or area would alleviate these circumstances, please give details:

DECLARATION

I/we confirm that I/We have read and understood the summary of Durham Key Options lettings policy. I/We certify that the details given in, or as supporting evidence to, this application represent a true record of my/our present circumstances.

I/We understand that it is an offence to give false information or withhold information relevant to my/our application and that if I/We do so, I/We could be liable to a fine up to £5000 (this figure is accurate as at April 1997, but you should be aware that this amount could alter).

I/We understand that Durham Key Options could take steps to withdraw an offer of accommodation or seek possession of a tenancy which has been granted as a result of a false statement made by the applicant or anyone acting on the applicant's behalf.

I understand that it is my/our responsibility to notify Durham Key Options should my/our circumstances change as this could affect my/our application.

I/We understand that Durham Key Options may wish to verify the information given in this application by making enquiries of the Police, Social Services, Probation Service, Landlords, Doctors, other departments of the council etc., to confirm whether there has been any involvement with myself or my family. I/We authorise Durham Key Options to obtain any relevant information from the appropriate organisation in relation to my/our application.

I/We understand that if I was to be allocated a property with any of the partner landlords, I must adhere to the conditions of my/our tenancy.

	Signature	Print Name	Date
Main applicant			
Joint applicant			

For office use only

ASSESSMENT

Housing priority on Medical/Welfare Grounds

Medical/Welfare Criteria (tick as appropriate)

Medical <input type="checkbox"/>	High Medical <input type="checkbox"/>	Urgent Medical <input type="checkbox"/>	No Medical Awarded <input type="checkbox"/>
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OT comments/recommendations if applicable

Signature	Date
Name	Job Title