



For official use only

# Medical Assessment For Housing

## Medical Assessment For Housing

This medical assessment application for housing has been developed by the landlords participating in Clackmannanshire Common Housing Register who are Clackmannanshire Council and Ochil View Housing Association.

**This medical should only be completed if:-**

- *A move will result in a significant improvement to you or a member of your households' health or make the health problem much easier to cope with. In assessing applications on health grounds please note that we will always consider whether or not the applicant's current accommodation could be adapted to meet their housing needs.*
- *Medical priority will not normally be awarded on health grounds which are considered to be inappropriate for assessment i.e. depression, anxiety, broken bones, sprains, pregnancy.*

If your health is affected in some way by your present accommodation all of the participating landlords will award priority in accordance with their own Allocation Policies.

The medical assessment is carried out by housing staff who may visit you at home. The assessment and final award with any recommendations will be shared between the participating landlords. Therefore, if you apply to Clackmannanshire Council or Ochil View Housing Association only one assessment will be made and the outcome shared between all the organisations.

Once you have completed the medical please return it along with any supporting documentation from any healthcare professional that is involved with your care confirming that a move to another home would significantly improve your health problem. This could be a letter from a GP, Occupational Therapist, Community Psychiatric Nurses or a Specialist Consultant.

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#### Medical Assessment

Clacks Council	Severe	
	Moderate	
	No Award	
Ochil View H.A	Gold	
	Silver	
	No Award	

## Priority is awarded as follows:

### Severe/High/Gold

- Where an applicant has a health problem and is unable to return to their home
- Or unable to continue living in their own home because they are not able to gain access to essential facilities and/or they are at significant risk
- Or due to significant and enduring mental illness they are unable to return or continue to live in their current home and/or environment
- And it is not practical to adapt their home to meet their needs

### Moderate/Medium/Silver

- Where an applicant has a health problem and is living at home and they are unable to gain access to essential facilities unaided
- And/or they would be housebound because they cannot get out of their home unaided or they are becoming less able to get out of their home unaided
- Or their mental illness severely restricts their ability to continue to live in their current home and/or environment or they are becoming less able to cope in their current home and/or environment due to their mental illness
- And it is not practical to adapt their home to meet their needs

#### Recommendation

Ground Floor Housing	
Level Access	
No Internal Stairs	
Additional Bedroom	
Wheelchair Adapted	
Sheltered Housing	
Overbath Shower	
Up to First Floor	
Other	
<b>Details:</b>	

***It is not enough that a health condition exists, it must be established that you are suffering a long-term condition which is directly caused by or seriously affected by your current housing condition and would be improved by moving to more suitable housing.***

Please answer the following questions, so that we can assess your application for re-housing on health grounds. If more than one person in your household is applying for medical priority then a separate form should be completed for each person. Only one medical award will be granted per household.

Title ..... Name ..... Date of Birth.....

Address .....

.....

Telephone Number .....

Email.....

Are you the Main or Joint Applicant Yes  No

If No relationship to the main applicant .....

**About your health** Please tell us about your health problem(s)

Condition 1 ..... Duration..... Years..... Months

Condition 2 ..... Duration..... Years..... Months

Condition 3 ..... Duration..... Years..... Months

**Please give details of how your condition affects your daily life in your present home and surroundings.**

.....  
.....  
.....

Do you have difficulty walking? Yes  No

**If yes do you need any of the following to help you get around**

Walking Stick  Tripod  Walking frame  Zimmer  Wheelchair

**If you use a wheelchair do you use it indoors or outdoors**

Indoors only  Outdoors only  Indoors and outdoors

Are you waiting to be discharged from hospital? Yes  No

Have you been admitted to hospital in the past year? Yes  No

If yes, which hospital, what was the date of admission, length of stay and reason for admission?

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.....

Have you had a community care assessment within the past year? Yes  No

Do you have regular contact/help from Social Work or from another source such as a voluntary agency? Yes  No

If yes provide details of the services you receive

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.....

If you receive Home care / Personal care, please state how often.

.....

.....

Please give details of the impact of your condition on your family and carers and how this could be improved by a change of house.

.....

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Have you applied for priority on health grounds before? Yes  No

If yes, when did you apply

.....

.....

Please tell us how your health condition is affected by your housing, and how you feel a move would help.

.....

.....

## About your present home

Is your home A flat  Bungalow  Two or more storey house

If a flat, what floor is it on

Ground Floor  1st Floor  2nd Floor  3rd Floor  4th Floor  Higher than 4th

Is your property accessible by a lift? Yes  No

How many stairs inside? .....

How many steps outside? .....

Do you have difficulty climbing the stairs in your home? Yes  No

Are there handrails on the stairs? One Side  Both sides  None

If yes, do you use the handrails? Yes  No

How many bedrooms in your home? .....

Are any bedrooms ground floor? Yes  No

Does your bathroom have: A bath only  Shower over bath  Separate shower unit

Level access shower  Wet Floor shower

Do you have any difficulty using your bath or shower? Yes  No

If yes, please describe your difficulty.....

Do you have to go upstairs/downstairs to the toilet? Yes  No

Do you have to go upstairs/downstairs to the bathroom / shower? Yes  No

Do you have to go upstairs/downstairs to the bedroom? Yes  No

Do you have any equipment/adaptations to help you? Yes  No

If your home has equipment/adaptations please describe what you have.

Please describe the type of heating you have

If your heating is causing health problems please describe them.

Does your home have dampness or condensation? Yes  No

If your home has dampness or condensation please tell us which room the dampness affects and also if the dampness affects your health.

Do you have difficulty getting to the shops and other places?

Yes       Some difficulty       No

Please tell us what these difficulties are.

.....

Does your illness or disability mean you need an extra bedroom? Yes       No

If yes, please explain why your health condition means that you require an extra bedroom.

.....

Do you need to stay in your current area to be close to a caring relative or friend? Yes       No

Do you need to move from your current area to be close to a caring relative or friend? Yes       No

Provide the name and address of your caring relative or friend

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.....

Do you have a garden? Yes       No

If yes, what size is your garden? Small       Medium       Large

If not covered by the questions so far please give details of why your accommodation is unsuitable.

.....

.....

What type of accommodation do you think would be best for you?

.....

.....

Would you prefer to stay in your present home if it could be adapted? Yes       No

If yes, please tell us why these adaptations cannot be carried out.

.....

.....

If no, please tell us why

.....

.....

## Obtaining further information

Name of family doctor .....

.....

Address of family doctor .....

.....

.....

When was your last GP appointment? .....

.....

Are you attending hospital out patient's clinic? Yes  No

If yes, name of clinic .....

.....

If you get regular support from anyone else (e.g. Occupational Therapist, Consultant) please provide their name and address.

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### Declaration

I give permission for the processing of the personal data information contained in this medical assessment form.

I confirm that the information given on this form is true, and also give my consent for the transfer of relevant information for the purpose of health priority assessment and housing allocation.

I understand that all information will be treated as strictly confidential and only be available to those who need to use it to assess my medical priority.

I am also aware that any medical priority granted may be restricted to certain areas and/or types of property. I am aware that this application and any medical award will be shared amongst the Common Housing Register landlords.

**Signed**

**Date**

