HOUSING APPLICATION
MEDICAL ASSESSMENT FORM

(Please note, you should only complete this form if you, or any other person included in your application, have a medical condition that is affected, or potentially affected, by your current housing circumstances.)

PART A (To be completed by Applicant)

NAME: .... DATE OF BIRTH: ....

ADDRESS: ....

Type of home (Please tick in the box provided)

Flat	☐	Bungalow	☐
Maisonette	☐	House	☐

If none of these, please specify: ....

If it is a flat, what level is it on? ....

How many stairs are there on the way to your front door? ....

Please tell us what health problems you have (or anyone else in your household)

....

....

....

Would you prefer to stay in your home if you could? Yes ☐

No ☐

1. **MOBILITY**

Confined to bed	☐
Totally wheelchair dependent	☐
Walks indoors with assistance of carer	☐
Walks indoors using a walking aid	☐
Walks outdoors with a walking aid	☐
No problems	☐

2. **STAIRS INDOORS**

- Unable to climb stairs ☐
- Requires assistance of carer ☐
- Will require assistance of lift ☐
- Will require assistance of hand rails ☐
- Adaptation currently in use ☐
- Has no problems ☐

3. **STAIRS OUTDOORS**

- Unable to climb stairs ☐
- Requires assistance of carer ☐
- Will require assistance of ramp/lift ☐
- Will require assistance of hand-rails ☐
- Adaptation currently in use ☐
- Has no problems ☐
- How many stairs would you be able to manage easily? ________

4. **BATHING AND PERSONAL CARE**

- Unable to access bathroom ☐
- Will require assistance of carer and adaptations ☐
- Will require assistance of carer and equipment ☐
- Will require assistance of carer ☐
- Will require adaptation ☐
- Will require equipment ☐
- Equipment currently in use ☐
- Has no problems ☐

5. **TOILET**

- Unable to access toilet ☐
- Will require assistance of carer and equipment ☐
- Will require assistance of carer ☐
- Will require assistance of equipment ☐
- Equipment currently in use ☐
- Has no problems ☐

6. **BEDROOM**

Does your illness or disability mean you need an extra bedroom?

Yes ☐

No ☐

If Yes, please tell us why you need this ....

....

....

7. **HEATING**

What sort of heating do you have? ....

What sort of heating would you prefer? ....

If you have any other comments on heating or ventilation in your home, please note them here.

....

....

8. **DAMPNESS**

Does your home have any dampness?

Yes ☐

No ☐

If this affects your health please tell us about it.

....

....

(Please note that written confirmation will be required from your landlord that dampness is present in your home before any priority could be given).

9. **OTHER HEALTH PROBLEMS**

a) If your health problem is not covered by any of the questions above, please tell us how your housing affects your illness or disability, and how you feel a move would help.

....

....

....

b) Have you had any equipment supplied because of your disability, if so please list.

....

....

c) Have you had any adaptations made to your home because of your disability?

....

....

d) Are you currently awaiting any aid or adaptations to be made to your home?

....

....

e) Do you currently have your name on any other housing list?

....

....

f) Please state, in your own words, why you wish to move.

....

....

....

10. OTHER AGENCIES

Hospital

Do you regularly attend a hospital or clinic? Yes ☐ No ☐

If so, which hospital/clinic? ....

What is your consultant's name? ....

Family Doctor

What is your doctor's name? ....

Address: ....
....

If you get regular support from anyone else, such as district nurse or occupational therapist please give their name and address if possible.

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

11. GETTING FURTHER INFORMATION

Do we have your permission to contact any of the above people if we need more information about your health? Yes ☐ No ☐

Signature of Applicant .... Date ....

Signature of Joint Applicant .... Date ....

Thank you for filling in this form

PART B (Office Use)

MEDICAL PRIORITY AWARDED:

(A) 30 Points House Type Required ....
(Including any special features ....)

(B) 15 Points

(C) 5 Points

(D) 0 Points

Signed: .... Designation ……..…………… Date ....

Confirmed: .... Designation …………………….. Date ....…

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