Lifestone Homes

Home4U

North Herts Council

North Hertfordshire Housing Partnership



Medical Assessment Form

Name of person who is ill/disabled	
Address	
Reg. No.	

Choice Based Lettings

www.home4u.org.uk

CONFIDENTIAL

Please use this form if you want or need to move and you or someone you are living with has a long term illness or disability. All the information will be treated as confidential.

Please try to give as much detail as possible as this will help us to help you.

If more than one person included in your application has a long term medical problem or disability that affects their housing, please complete a separate form for each person.

If you need help in completing the form, please ask, we will be happy to help.

ABOUT YOU

Name of the person who is ill or disabled:

If this is a child, what is the surname of the parent?

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ ☐ Male ☐ Female

Do you have your own bedroom? ☐ Yes ☐ No

If no, who do you share with? Give relationship and age of other person(s)

Please tell us about all the people who live permanently in your home

Full name	Relationship to you	Date of birth

Present accommodation

☐ House ☐ Flat ☐ Maisonette ☐ Bungalow ☐ Room in shared house

☐ Other Please give details No. of Bedrooms within property ☐

Floor level of flat / maisonette: ☐ ground ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th or above

Is there a lift? ☐ Yes ☐ No

Is your heating ☐ Gas ☐ Electric ☐ Other ☐ None

How is the heat provided?
(For example, radiators, storage heaters, gas fire and so on).

Which rooms are heated? ☐ Bedrooms ☐ Living Rooms ☐ Bathoom ☐ Kitchen

Is your bathroom ☐ upstairs ☐ downstairs

Is your toilet ☐ upstairs ☐ downstairs ☐ both

Please describe the health problem or disability that affects you now

How long have you been affected by the health condition(s)/disability?

Because of these health condition(s), why is the property you now live in not suitable?

How would your condition(s) improve if you moved to a suitable property?

What sort of accommodation do you need?

Would you need any alterations if we could offer you somewhere else to live Eg bath rails? If yes, please list the alterations.Please supply a copy of your occupational therapist's report detailing the adaptations needed.

☐ Yes ☐ No

Do you get any help or are awaiting support from people like: (please tick the box(es) that apply to you)

☐ District nurse ☐ Occupational Therapist or similar ☐ Home Help ☐ Meals on Wheels

☐ Mental Health Team ☐ Community Psychiatric Nurse ☐ Learning Disabilities Team

☐ Other ☐ No support

List how often

If so, please give us their name(s) and address(es): Complete on a separate sheet if necessary

Please tell us what medication you take and the dose:

YOU MUST ENCLOSE A PHOTOCOPY if you are on medication, of the repeat prescription slip for this form to be considered.

Medicine:

Dose: How many times a day do you take this?

How long have you been taking this?

Medicine:

Dose: How many times a day do you take this?

How long have you been taking this?

Medicine:

Dose: How many times a day do you take this?

How long have you been taking this?

Medicine:

Dose: How many times a day do you take this?

How long have you been taking this?

TREATMENT Are you receiving any treatment for a condition?
(e.g. Chemotherapy, Physiotherapy, Psychotherapy, Radiotherapy) ☐ Yes ☐ No

If yes, which, providing details of how long you have been receiving this treatment

Your doctor's name and address:

Your doctor's telephone number:

Date last seen and outcome:

If you have a consultant, please give their name(s) and hospital address:

Which medical condition are you seeing the consultant for?

Your consultant's telephone number:

Date last seen and outcome:

ABOUT THE HOME YOU LIVE IN NOW

Do you have difficulty using stairs? Yes ☐ No ☐

Do you have to climb stairs or steps to your front door? Yes ☐ No ☐ How many? ☐

Is your home all on one level once you are inside? Yes ☐ No ☐

Have any alterations been made to your home because of a medical problem or disability? Yes ☐ No ☐ On a waiting list ☐

If so give details below:

Are you registered disabled? ☐ Yes ☐ No

If yes, please provide evidence of registration

Do you use a wheelchair? ☐ Yes ☐ No

If yes, do you use it – ☐ Inside ☐ outside ☐ both

Do you use a Walking Frame? ☐ Yes ☐ No

If yes, do you use it – ☐ Inside ☐ outside ☐ both

Do you use a Walking Stick? ☐ Yes ☐ No

If yes, do you use it – ☐ Inside ☐ outside ☐ both

Can you bathe, wash and dress yourself without help? ☐ Yes ☐ No

If no, who helps you?

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Can you do your shopping without help? ☐ Yes ☐ No

If no, who helps you?

Can you do your housework without help? ☐ Yes ☐ No

If no, who helps you?

Do you require assistance at night? ☐ Yes ☐ No

Please provide details and evidence of this:

Are you receiving Disablement Benefits? (eg Employment and Support Allowance (ESA), Disability Living Allowance (DLA), Attendance Allowance (AA), Personal Independent Payment (PIP), Industrial Injury Payment).

☐ Yes ☐ No

If yes, please specify including date it awarded and provide evidence of this.

If yes to DLA, which level applies to you?

Mobility: ☐ High ☐ Low

Care: ☐ High ☐ Medium ☐ Low

Please attach a photocopy of your DLA entitlement letter showing the benefit you receive.

Please use this space to provide any other information you want to give us about your medical condition or disability:

DECLARATION

I / We have checked the details written on this form and declare that it is true and complete in every detail.

I / We understand that the Partner may pass this information to any Housing Association to which I may be nominated.

I / We give my permission for this information to be checked by contacting persons as reasonably considered prudent by the partners such as the DWP, Social Services, Employment Service, bank, building society, estate agent, solicitor, landlord, Immigration Service, doctor, employer, Housing Associations, Councils.

I / We understand that the information I have given is confidential and can only be used in ways allowed by the Date Protection Act. I / We understand that you may share this information with other organisations to prevent and detect fraud.

I / We will tell the partner if there is any change in my / our circumstances.

I / We understand that if I have given information which is not true, I may be prosecuted and that I / we may be evicted from any property which I / we may have been given.

I authorise the release of any information, which may be relevant to my housing application or to my medical condition, held by other agencies/individuals,to North Herts Housing Partnership. NHHP will not be responsible for any fees or costs in obtaining information.

Signed:

Date: ☐☐ / ☐☐ / ☐☐☐☐

Has someone helped you complete this form? ☐ Yes ☐ No

If yes, please provide their details below

Name:

Address:

Contact details:

Relationship:

Please note it may take up to six weeks to receive confirmation of your medical assessment.