

Reference No:

<h2>Housing Application Medical Assessment Form</h2>

Please read the leaflet “Allocations Policy Medical Assessments” before filling in this form.

You should apply for a medical assessment if you think that you or a member of your household’s health or disability is being made worse by your current housing situation. A disability is a physical or mental illness/impairment which has a substantial and long term adverse effect on normal day-to-day activities.

This is not an assessment of the severity of the medical condition or disability but an assessment of the need for another house that would alleviate the medical condition or disability.

You do not need any letters of support from your doctor to apply. However, if you already have any information relating to your medical circumstances, you can attach this to your medical assessment form.

FOR OFFICE USE ONLY	
Checked by	Supporting documents received
Form received
Sent to Medical Advisor

Guidance Notes

If you need any help with this form please contact us on 0300 1234566.

What you should do:

- Fill in the medical assessment form in black ink giving as much detail as possible.
- Sign and date the form.
- Return the form in person to your local area housing office or send it back to the Housing Needs Section.
- **Please try to answer all of the questions.** We will use the information you give us to assess your households housing needs. This includes if you are eligible to have your heating upgraded. We need as much information as possible to make the correct decision.

What happens next?

- We will consider the information and decide whether any medical points can be awarded.
- We will write to you when a decision has been made.

All of the information you give us will be treated as strictly confidential.

Medical assessment form

1. **Name of applicant/s** **Date of birth**

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- Name of person/s claiming medical priority** **Date of birth**

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2. **Your contact details**

Address you are currently living at:	
Postcode:	
Phone No:	
Mobile No:	
Email address:	

3. **Correspondence address, if different from above**

Address for mail only:	
Postcode:	

4. Details of your current home:

Please tick the box that best describes your current circumstances:

Tenure	✓	Tenure	✓
A Moray Council tenant		A lodger	
A housing association tenant		In a caravan	
A tenant with another local authority		In hospital	
A private tenant		A member of the armed forces	
Living in a property I own		A tied or service tenancy	
Staying with parents		In prison	
Staying with relatives or friends		No fixed abode	
Other (please give details)			

5. Is your home a: (please tick)

	✓		✓
House		Ground floor flat	
Bungalow		1st floor flat	
Maisonette		2nd floor flat or above	
Bedsit			
Number of steps outside		Number of stairs inside the property	

Is your home:

	Yes	No
On the level		
On/up a hill		

6. How many bedrooms are there in your current accommodation?

Of these how many bedrooms does your household have use of in your current home

(household = you and those people moving with you)

7. How long have you lived at this address?

years months

8.a) Please describe the heating in your home (please tick)

	✓
Gas	<input type="checkbox"/>
Solid fuel	<input type="checkbox"/>
Electric	<input type="checkbox"/>
Oil	<input type="checkbox"/>

b) Is there a radiator in every room? Yes No

c) Does your current heating system affect you/their health?
Yes No

If yes, please give details:

d) Are you a Moray Council tenant applying for a heating replacement? Yes No

If yes, why do you need a heating replacement?

Please tell us about your current home

10. Does your current home have any of the following facilities? (Please tick)

	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
A bath	<input type="checkbox"/>	A ceiling track/mobile hoist	<input type="checkbox"/>
A bath with an over bath shower	<input type="checkbox"/>	A ramp	<input type="checkbox"/>
A level access shower	<input type="checkbox"/>	A stair lift	<input type="checkbox"/>
Hand rails	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>
Garage/parking space	<input type="checkbox"/>	None of these	<input type="checkbox"/>

11. Do you use any specialist equipment?

Yes No

If yes, please give details below.

12. Is there a toilet upstairs? Yes No

13. Is there a toilet downstairs? Yes No

14. Is there a bathroom upstairs? Yes No

15. Is there a bathroom downstairs? Yes No

Who is this assessment about?

- 16. Please tell us about your/their ill health or disability and any medication that is being taken or treatment required.
(Applies only to those wanting to be re-housed.)**

Name	Date of birth
Medical condition	Medication / treatment
Name	Date of birth
Medical condition	Medication / treatment
Name	Date of birth
Medical condition	Medication / treatment

- 17. How does your/their current home affect your/their health and why do you/they want to move?
(Continue on page 14 if more space required)**

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Please answer the following questions about you and members of your household.

18.

	Yes	No
Are you/they registered blind?		
Are you/they registered disabled?		
Do you/they have an assistance dog?		

19. **Do you/they have difficulty walking?**

Yes No

If you/they can only walk a short distance, approximately how far are you/they able to walk?

.....

Are you/they unable to walk? Yes No

20. **Do you/they have difficulty climbing stairs?**

	✓
No	
Slowly (If yes please answer Question 21)	
With great effort (If yes please answer Question 21)	
Unable to climb internal stairs	
Unable to climb external steps	

21. a) **How many internal stairs are you/they able to climb?**

b) **How many external steps are you/they able to climb?**

22. Do you/they use any of the following?

	✓
Walking stick	
Crutches	
Zimmer	
Wheelchair	
Mobility scooter	
None of the above	

23. Do you/they have difficulty getting on or off the toilet?

Yes No

24. Do you/they have difficulty getting in or out of the bath?

Yes No

25. If you have a shower, do you/they have difficulty getting in or out?

Yes No Not applicable

26 a. Do you/they get Home Care at the moment?

Yes No

b. If yes, how often do you/they get Home Care (please tick)

	✓
Less than once a week	
At least once a week	
Most days	

27. Approximately, how far in miles are you from your nearest:

Shops/Post Office

Bus stop

28. Do you/they need to be near support services?

Hospital Yes No

Doctor/Surgery Yes No

Relatives Yes No

Other support services – please give details

29. Are your relatives currently giving care or support to you or a member of your household?

Yes No

If 'yes', please provide details:

Relative's name	
Relationship	
Relative's address	
Postcode	
Phone number	
How often is support required?	

Can we contact this person to discuss your application?

Yes No

30. Do your relatives have difficulties in providing support due to location?

Yes No

31. Are you a car owner? Yes No

32. Do you, or a member of your household, need a property with any of the following due to your/their medical circumstances?

	Yes	No
Level access shower		
Accommodation on the ground floor with no external or internal stairs		
Accommodation with a stair lift		
Level access entry		
Accommodation fully adapted for indoor wheelchair use		
Sheltered accommodation		
Do you/they use specialised equipment to manage your/their illness		
Is there space to store such equipment		
Do you require an extra bedroom due to your/their medical condition (if yes please specify below.)		

Name of person requiring extra bedroom

Are they currently sharing a bedroom? Yes No

If yes, who with?

Reason for requesting an extra bedroom (medical grounds only)

.....

.....

33. Do you/they have a full-time carer?

Yes No

34. Are you/they in receipt of Higher Disabled Living Allowance (care component)

Yes No

If 'yes', please submit a copy with this form

35. Are you/they in receipt of Higher Attendance Allowance

Yes No

If 'yes', please submit a copy with this form

36.a) Have you/they attended hospital for emergency treatment for your/their medical condition(s) in the last 6 months?

Yes No

If 'yes', when did you/they attend? ___ / ___ / ___

Please give details below. Make sure you tell us the name of the hospital you/they attended.

b) Have you/they stayed overnight in hospital (for non-emergency treatment) due to your/their medical conditions(s) in the last 6 months?

Yes No

If 'yes', when did you/they attend? ___ / ___ / ___

Please give details below. Make sure you tell us the name of the hospital you/they attended.

37. You must fill in questions (A) & (B) as this information is important to enable us to process your medical needs.

(A)

Name of doctor:	
Address of doctor:	
Postcode:	
Phone number:	

Other (e.g. consultant/specialist, social worker, occupational therapist)

(B)

Name:	
Address:	
Postcode:	
Phone number:	

Declaration and authority to seek information

- I/we confirm that the details I/we have given are to the best of my knowledge true in every respect.
- I/we confirm my/our agreement for you to access medical details from my doctor or specialist in connection with my/our application.
- I/we undertake to notify you of any change in the details provided on the application form.
- I/we authorise you to make any necessary enquiries in accordance with the Data Protection Act 1998. This may include sharing your information with other council departments.
- I/we authorise you to make any referrals necessary in connection with my/our application. (This might include referrals to other services such as Occupational Therapy). I/we consent to any visits that may be needed to further assess my/our situation.

Signed (applicant):

..... Date

Signed (other adult members of the household aged 16 or over) that are included in question 16:

..... Date

Signed on behalf of applicant

..... Date

Relationship to applicant

Please tell us why applicant is unable to complete the form:

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

Please return this form to:

<p>Housing and Property The Moray Council PO BOX 6760 Elgin IV30 9BX</p>



If returning by post please make sure a **large letter** stamp is used

THIS PAGE IS FOR OFFICE USE ONLY

1. Medical Priority considered for:

Name	Medical Condition	Award Date	Category

2. Household requires:

Additional requirement	Essential ✓	Recommended ✓	Not Necessary ✓	Further clarification
Additional Bedroom (for medical needs only)				
Stairlift				
Ground Floor Accommodation				
Sheltered Accommodation				
Very Sheltered Accommodation				
Wheelchair Accessible Accommodation				
Fully Wheelchair adapted property				
Adaptations to existing home				
Over Bath Shower				
Level Access Shower				
Occupational Therapist Assessment required				
WC Downstairs				

3. People contacted

Has a report been requested from the applicant's doctor?

Yes No

Date Received

Has any other agency been contacted?

Yes No

If yes, who has been contacted?.....

4. Reasons for category award

5. Additional comments

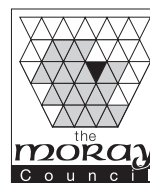
Signed:

Date:

For Housing Needs use only:

Main Applicant	
Ref No:	
Previous Award	
OT Report Requested:	
Date:	By:
OT Report Received	
Date:	By:
EHD Inspection Requested	
Date:	By:
EHD Inspection Received	
Date:	By:
DLA Requested	
Date:	By:
DLA Received	
Date:	By:
Medical Comments Updated	
Medical Answers Updated	
Housing Requirements Notes Updated	
Check Application Placed on Correct List: Main/Ground/Sheltered	
Update Nos of Bedrooms for Medical Needs if applicable	
Update Special Needs Spread Sheet if applicable	
Entered By:	
Checked Date:	By:

To be returned to applicant:



Acknowledgement of Housing Application Medical Assessment form

Applicant Name

Applicant Address

Signature of Officer receiving completed form

Office date stamp

We hope to advise you of the outcome of your Medical Assessment within 28 days.

If your circumstances change, please let us know immediately.

If you want to check the information you have given on your application, please contact us. You have a right to see this information.

Data Protection Act 1998

The personal details you give us on this form will be stored on our computer. This information will be covered by the Data Protection Act 1998, so we will not pass it on to others without your permission.

We will only use your details to help us find suitable housing for you.

Access to personal files (Housing) (Scotland) Regulations 1992

You can ask to see any information we hold about you on Computer or in our files.

If we are unable to show your information, the reason will be given at the time.



Buckie Access Point

13 Cluny Square
Buckie
AB56 1AJ

Elgin Access Point

Council Office
High Street
Elgin, IV30 1BX

Forres Access Point

Auchernack
High Street
Forres, IV36 1DX

Keith Access Point

The Institute
Mid Street
Keith, AB55 5BJ

Phone: 0300 1234566

If you need information from the Moray Council in a different format, such as Braille, audio tape or large print, please contact:

如果閣下需要摩里議會用你認識的語言向你提供議會資訊的話，請要求一位會說英語的朋友或親人與議會聯繫

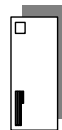
Jeżeli chcieliby Państwo otrzymać informacje od samorządu rejonu Moray w swoim języku ojczystym, Państwa przyjacieli lub znajomy, który mówi dobrze po angielsku, może do nas

Se necessita de informação, do Concelho de Moray, traduzida para a sua língua, peça o favor a um amigo ou parente que fale Inglês para contactar através do:

Jeigu Jums reikalinga informacija iš Moray regiono Savivaldybės /Moray Council/, kurią norėtumėte gauti savo gimtąja kalba, paprašykite angliškai kalbančių draugų arba giminaičių susisiekti su mumis

Чтобы получить информацию из Совета Морэй на Вашем языке, попросите, пожалуйста, Вашего друга или родственника, говорящих по английски, запросить ее

Si necesitas recibir información del Ayuntamiento de Moray en tu idioma. Por favor pide a un amigo o familiar que hable inglés que:



Project Officer
Chief Executive's Office
High Street
Elgin, IV30 1BX



Phone: 01343 563319



Email: equalopportunities@moray.gov.uk



Textphone (Wednesday or Thursday only):
18002 01343 563319