MEDICAL SELF ASSESSMENT FORM

Please complete this form as fully as possible if you have indicated that you have medical reasons for needing to be rehoused and that your current accommodation is affecting your health.

If more than one person on the application has a medical need to be considered, please complete an additional form.

1. Details of person to be considered on medical reasons:

Name: **DOB:**

Address:

Telephone number:

2. Details of medical condition

Please provide brief details of relevant medical conditions / disabilities /mental health problems you have which you think would improve or be easier for you to manage if you were rehoused. Please tell us how long you have had the condition

Please provide a copy of your prescription dated within the past2 months.

Name and Address of GP :

Are you currently under the care of any specialist at the hospital? Y / N
If so, please give details

3. What kind of property are you living in now :

House		Number of Bedrooms	
Bungalow		Number of people residing	
Flat • Floor • Lift available	G / 1 / 2 / 3 / 4+ Yes / No		
Maisonette		Tenure eg tenant, lodger etc	
Hotel/Hostel			
Other (give details)			

4. Adaptations and equipment

Do you have any of the following adaptations in your home? Please tick and provide details

Level Access Shower		
Adapted bathroom		
Stairlift		
Vertical Lift		
Wheelchair vertical lift		
Ceiling track hoist		
Extra Bannisters		
Adapted Access		
Other (please state)		

Were these adaptations provided for you? Yes / No

If Yes please provide the date when they were provided :

Have you applied for any adaptations or are waiting for any adaptations? Yes / No

If yes, please provide details

Have you been assessed by an Occupational Therapist within the last 12 months?

Yes / No

If Yes please provide the name of your OT if known:

Please tick here if you give consent for the OT to provide us with a copy of your report ☐
If No would you consent to a referral being made to an Occupational Therapist?

Yes/ No

If adaptations were provided, would you be able to stay in your current home?

Yes / No

Will you require adaptations in your new home ? **Yes / No**

If Yes please provide details of the adaptations required :

Support you receive

Do you currently receive any support to assist you with your daily living needs

Yes / No **If yes please provide details below**

	Family	Friend	Care Agency	District Nurse	Scheme Manager	Other
Shopping						
Personal Care						
Getting up/ going to bed						
Household chores						
Other (Specify)						

5. Your mobility

Please tick all that apply

Can you walk:

Unaided ☐ Using a walking stick ☐ Using a walking frame ☐

Use a wheelchair Yes / No If yes is this for : inside / outside

Inside your home

Is your bathroom Upstairs ☐ Downstairs ☐

Is your toilet Upstairs ☐ Downstairs ☐ Both ☐

How many stairs are in your home :

Is your staircase : straight ☐ curved ☐ landing on the stairs ☐

If you are unable to manage these stairs, please provide details:

If you use your main living room or another downstairs room as your bedroom, please give details.

Outside your home

Is your mobility outside your home **:**

very good ☐ good ☐ reasonable ☐ poor ☐ very poor ☐

Do you have steps to the front of your home? Yes / No if yes, how many?

Do you have steps to the rear of your property? Yes / No if yes, how many?

Do you have grab rails or a ramp to the outside of you home ?

If yes please give details and state if they are to the front or rear of the property or both:

What type of transport do you rely on ?

My own Car □ Public Transport □ Relatives Car □ Other □

6. **Please provide details of any other agencies you may be involved with**

	Name	Address	Phone number
Social worker/ Care Manager			
CPN			
Support Worker			
Other			

Where possible please provide additional information in support of your application, letters from your specialists/consultant, letters from a psychiatrist or psychiatric nurse, occupational therapy reports

Please state why you think your current accommodation is unsuitable for your needs and how your medical conditions would be improved or easier to manage if you were rehoused?

IF THIS FORM HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON NAMED ON THE FORM PLEASE PROVIDE THE NAME OF THE PERSON COMPLETING THIS FORM AND THEIR RELATIONSHIP TO THE NAMED PERSON.

I confirm that all the information provided on this form is true and correct to the best of my knowledge. I understand that Under One Roof will treat any information it receives in the strictest confidence and hold it in line with the Data Protection Act 1998. I give consent to the disclosure of the information contained in this form being shared by Under One Roof with for example my previous landlords, relevant agencies and the local council to check that the information provided is accurate in order to protect public funds.

Signature

Date

Completed forms should be returned to the Under One Roof team. You can log into your online account and upload the form, email it to info@under-one-roof.org.uk or send it to Under One Roof, Helena Central, 4 Corporation Street, St Helens, WA9 1LD.

The information contained on the form will be reviewed by the Under One Roof team and one of the following decisions will be made :

- **Extra information is required before an assessment can be made**
- **No additional priority will be awarded at this stage**
- **Additional priority will be awarded based on the information provided**
- **Your form will be considered by the medical assessment panel for higher priority cases**.

Office Use Only

Medical Level Awarded :
Date :
Officer :