Home-Link

Medical Self-Assessment Form Confidential

If you have an illness or disability **that makes your home unsuitable** Home-Link will assess your need to move in accordance with the priorities set out in the Lettings Policy.

You do not need a letter from your doctor because we will request one if required. Medical priority will **no**t be given for (among other things):

- Pregnancy
- Overcrowding
- Minor illnesses (e.g. colds and flu)
- Poor conditions in your home, such as damp
- People who are adequately housed
- Temporary disability such as a broken limb

Please answer all the questions; otherwise assessment of your application for re-housing could be delayed. Please be aware that we may need to visit you to verify the information you give on this form.

Please complete a separate medical self-assessment for each person's details.

Please do not submit another form unless your medical condition changes.

Home-Link Number:

About You

Name of person in the household with the medical need to move:

Address:

Date of birth:

About Your Home

Type of home you live in (please choose one):

Flat: ☐ Maisonette: ☐ House: ☐ Bungalow: ☐ Bedsit with shared facilities: ☐

Other (please describe):

No. of bedrooms in your home (please choose one): 0: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐

Do you share part of your home with anyone other than your family?: Yes: ☐ No: ☐

If you answered yes to the previous question:-

1. Which part(s) of your home do you share? (tick all that apply)

bathroom: ☐ toilet: ☐ kitchen: ☐ bedroom: ☐ hallway: ☐

2. Who do you share with?

Name: Relationship to you:

continue on a separate sheet if necessary.

If you are in a flat or maisonette, which floor is your front door on? (please choose one):

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

Is there a lift or stairlift to the communal entrance?: Yes: ☐ No: ☐

How many steps are there to the front door of your home?:

Inside: Outside:

On which floor is your bathroom?:

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

On which floor is your toilet?:

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

On which floor is your additional toilet?:

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

On which floor is your additional bedroom?:

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

On which floor is your living room?:

Basement: ☐ Ground: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ other (please state): ☐

How is your living room heated?: Gas central heating: ☐ Electric central heating: ☐

Gas fire: ☐ Storage heater: ☐ Electric bar fire: ☐ Electric convector heater: ☐ Open fire: ☐

Other (please state): No heating in Living Room:

Are the bedrooms heated?: Yes: ☐ No: ☐

Have any adaptations been provided in your current home to help your household to manage in it?

Specialist bath: ☐ Adapted WC: ☐ Adapted kitchen: ☐ Standing Crossover: ☐

Through-floor lift: ☐ Stair lift: ☐ Grab rails: ☐ Hoist bathroom: ☐

Hoist Bedroom: ☐ Hoist L/Room: ☐ Hoist WC: ☐ External Rail: ☐

Step-in Shower Tray: ☐ Key safe: ☐ Lever taps: ☐ Low level switches: ☐

Parking Bay: ☐ Car port: ☐ Integral Garage: ☐ Shower over bath: ☐

Ramp Access front: ☐ Doorbell for hearing impaired: ☐

Ramp Access back: ☐ Graduated Floor Shower: ☐

Other (please describe):

About Your Medical Condition

Name & brief description of your illness or disability:

How does your current home affect your health?:

About Your Treatment

If you are currently receiving any treatment or medication please give details:

Name of Treatment/ Medication	Amount Taken/ Dose	How Often	When started

Please describe the history of your condition

Please describe the history of your medical condition/ disability (e.g. has it got better or worse, does it come and go?):

About People who Provide Help with your Health Problems

Please give your family doctor's name and practice address:

Name:

Address:

Postcode: Phone number:

Please give details of all the professionals (i.e. clinics, therapists, consultants and specialists) you are currently registered with or have seen within the last year about the medical condition(s) you have described:

Service 1:	
Last date visited:	
Name:	
Address:	
Postcode:	Contact telephone number:

Service 2:	
Last date visited:	
Name:	
Address:	
Postcode:	Contact telephone number:

Service 3:	
Last date visited:	
Name:	
Address:	
Postcode:	Contact telephone number:

Service 4:	
Last date visited:	
Name:	
Address:	
Postcode:	Contact telephone number:

About Hospital Admissions

Please give details of any hospital admissions relevant to the medical condition you have described:

Hospital 1 Name:

Hospital Location:

Reason for Admission:

Date admitted: Month: Year:

Length of Stay **(please circle whichever applies):** No. Days / Weeks / Months / Years

Your Hospital Reference Number:

Hospital 2 Name:

Hospital Location:

Reason for Admission:

Date admitted: Month: Year:

Length of Stay **(please circle whichever applies):** No. Days / Weeks / Months / Years

Your Hospital Reference Number:

Are you registered disabled?: Yes: ☐ No: ☐

Do you use a wheelchair?: Yes: ☐ No: ☐

If yes to previous question:

When do you need to use your wheelchair? (choose one):

1. All the time(indoors and outdoors): ☐
2. Some of the time, usually outdoors: ☐
3. Other (please explain):

Can you walk upstairs? (choose one):

I do not have a problem with steps or stairs: ☐

Stairs are difficult for me,
but I can manage one or two steps: ☐

I cannot manage steps or stairs at all: ☐

Authority to Obtain Medical Information

We may need to write to your Doctor, Social Worker or Therapist for more information.
We cannot do this without your consent in accordance with the Data Protection Act 1998.

Please complete the following declaration.

I authorise my Doctor/Social Worker/Therapist (or the Doctor/ Social Worker/ Therapist of my child who is under 16 or person who is unable to sign on their own behalf) to disclose information about my physical and/or mental health to the Council's Medical Adviser and/or my Housing Officer and/or other housing bodies to which I am applying for housing.

Name (please print):

Signature: **Date:**

If signing on behalf of a minor child or a person who is unable to sign on their own behalf please give your relationship to him or her:

Warning: If you do not sign this authorisation giving your permission to contact the Doctor/ Social Worker/ Therapist we may not be able to award you any medical priority.

Declaration of Truth

By submitting this form I agree that I will notify my housing officer of any changes in my circumstances that affect the details I have given on it.

I certify that the information I have given on this form is true and correct to the best of my knowledge. I understand that knowingly making false statements could give my council or housing association grounds for deferring, cancelling or amending my housing registration, or for prosecuting me. I also understand that I could lose any tenancy granted as a result of my giving false information.

We will control the information you have given us under the data protection legislation. We will use the information that you, or other people give us, to consider your application for housing. We may share your details with other housing associations, housing providers and statutory organisations to help us manage your applications. We may store your details on computer, but we will not keep your records for longer than is necessary."

Applicants Signature: **Date:**