



APPLICATION FOR MEDICAL PRIORITY HOUSING

Please fill in this form **ONLY IF YOU**, or someone who lives with you:

1. has a **SERIOUS, LONG TERM** health complaint **AND**;
2. a change of house would be beneficial, and is urgently required.

In the first part of the form, you are asked to give details of your present housing situation. Please take care in completing this part, as incorrect information may lead to a faulty assessment of your application. (The Association will double-check this part to try to ensure complete accuracy).

In the second part of the form, you are asked to give details of your health problem **AND** to explain **WHY** a change of house would be beneficial. **IT IS ESSENTIAL THAT YOU GIVE AS MUCH INFORMATION AS YOU CAN IN THIS PART.**

Finally, you are asked to give some background medical information.

Your application will be assessed by the medical adviser to the Association **WHOSE DECISION IS FINAL.**

No appeals are permitted, and a request for a second assessment will only be allowed where there has been a significant change in circumstances.

REMINDER: DO NOT FILL IN THIS FORM UNLESS YOU OR SOMEONE ELSE WHO LIVES WITH YOU:

1. **HAS A SERIOUS LONG TERM HEALTH COMPLAINT AND;**
2. **A CHANGE OF HOUSING WOULD BE BENEFICIAL.**

APPLICATION FORM

PART ONE

1. Name: _____

3. Address: _____

4. Person for whom medical priority is being sought if different from above:

5. Please give details of everyone in your household, beginning with yourself.

<u>Name</u>	<u>Date of Birth</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you a sub tenant? YES / NO

6. What type of property do you live in. Please circle as applicable:

Cottage / Flat / Maisonette / Four in a block flat / Multi storey block

Other (please specify): _____

7. Is your present accommodation situated on the ground floor? YES / NO

8. How many bedrooms are there in your present accommodation? _____

9. Do you or your partner have a medical condition that requires the need of a separate bedroom?

YES/NO

10. What kind of heating does your present accommodation have?
Gas / Electric / Solid Fuel / Other
11. Is the property centrally heated? YES / NO
12. What size of garden do you have?
Large / Medium / Small / No Garden
13. Do you have shops within easy reach? YES / NO
14. Do you have your own transport? YES / NO
15. Would you say the area in which you live is hilly or flat? HILLY / FLAT
16. How many outside stairs are there to your front door? _____

PART TWO

This part should be filled in by, or on behalf of the person who has the health problem.
(See Question 3 in Part One)

1. Describe your health problem in as much detail as you can.

- 2a) What kind of houses have you applied for? Delete as applicable.

Cottage	YES / NO	Flat	YES / NO
Four in a block	YES / NO	Bungalow	YES / NO
Amenity Housing	YES / NO		

- 2b) Do you require any of the following specific house types?

Wheelchair housing	<input type="checkbox"/>	Sheltered housing	<input type="checkbox"/>
Level access	<input type="checkbox"/>	No internal stairs	<input type="checkbox"/>

3. Where do you want to live? (Please tick):

Alloa _____

Tullibody _____

Hillfoots _____

4. Please explain why a move to the kind of house you want would help your health complaint?

Please provide full information.

5. Are you registered disabled? YES / NO

6. Are you registered blind? YES / NO

7. Is there a smoker in the household? YES / NO

8. Please give details of your Family Doctor:

9. When did you last consult him/her? _____

10. Have you been admitted to Hospital within the past year? YES / NO

Date of Admission (Month and Year) _____ Length of Stay _____

Hospital _____

Hospital Doctor _____

Reason for Admission _____

11. Are you attending a hospital clinic or outpatients clinic? YES / NO

If yes, please give name of clinic _____

DECLARATION

I hereby give permission for the Association's medical adviser to ask the family doctor / hospital specialist, in confidence, for further information. I acknowledge that there is no right of appeal. I am also aware that any medical priority granted may be restricted to certain areas and/or types of property.

Signed: _____

Date: _____

Please return to: -

Ochil View Housing Association
Ochil House
Marshall
Alloa
FK10 1AB

FOR OFFICIAL USE ONLY

Medical Assessment

Recommendations

Category			Ground Floor Housing		
Low			Level Access		
Medium			No Internal Stairs		
High			Additional Bedroom		
No Award			Wheelchair Adapted		
			Sheltered Housing		
			Overbath Shower		