OCHIL VIEW
Housing Association Limited

PARAGON
HOUSING ASSOCIATION LIMITED

Clackmannanshire
Council

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Medical Assessment For Housing

Medical Assessment For Housing

This medical assessment application for housing has been developed by the landlords participating in Clackmannanshire Common Housing Register who are Clackmannanshire Council, Ochil View Housing Association and Paragon Housing Association.

This medical should only be completed if:-

- ***A move will result in a significant improvement to you or a member of your households' health or make the health problem much easier to cope with. In assessing applications on health grounds please note that we will always consider whether or not the applicant's current accommodation could be adapted to meet their housing needs.***
- ***Medical priority will not normally be awarded on health grounds which are considered to be inappropriate for assessment i.e. depression, anxiety, broken bones, sprains, pregnancy.***

If your health is affected in some way by your present accommodation all of the participating landlords will award priority in accordance with their own Allocation Policies.

The medical assessment is carried out by housing staff who may visit you at home. The assessment and final award with any recommendations will be shared between the participating landlords. Therefore, if you apply to Clackmannanshire Council, Ochil View Housing Association or Paragon Housing Association only one assessment will be made and the outcome shared between all the organisations.

Once you have completed the medical please return it along with any supporting documentation from any healthcare professional that is involved with your care confirming that a move to another home would significantly improve your health problem. This could be a letter from a GP, Occupational Therapist, Community Psychiatric Nurses or a Specialist Consultant.

Priority is awarded as follows:

Severe/High/Gold

- Where an applicant has a health problem and is unable to return to their home
- Or unable to continue living in their own home because they are not able to gain access to essential facilities and/or they are at significant risk
- Or due to significant and enduring mental illness they are unable to return or continue to live in their current home and/or environment
- And it is not practical to adapt their home to meet their needs

Moderate/Medium/Silver

- Where an applicant has a health problem and is living at home and they are unable to gain access to essential facilities unaided
- And/or they would be housebound because they cannot get out of their home unaided or they are becoming less able to get out of their home unaided
- Or their mental illness severely restricts their ability to continue to live in their current home and/or environment or they are becoming less able to cope in their current home and/or environment due to their mental illness
- And it is not practical to adapt their home to meet their needs

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Medical Assessment

Clacks Council	Severe	
	Moderate	
	No Award	
Ochil View H.A	Gold	
	Silver	
	No Award	
Paragon H.A	Absolute	
	High	
	Medium	
	Low	
	No Award	

Recommendation

Ground Floor Housing	
Level Access	
No Internal Stairs	
Additional Bedroom	
Wheelchair Adapted	
Sheltered Housing	
Overbath Shower	
Up to First Floor	
Other	
Details:	

It is not enough that a health condition exists, it must be established that you are suffering a long-term condition which is directly caused by or seriously affected by your current housing condition and would be improved by moving to more suitable housing.

Please answer the following questions, so that we can assess your application for re-housing on health grounds. If more than one person in your household is applying for medical priority then a separate form should be completed for each person. Only one medical award will be granted per household.

Title ..... Name ..... Date of Birth .....

Address .....

.....

Telephone Number .....

Email .....

Are you the Main or Joint Applicant Yes ☐ No ☐

If No relationship to the main applicant .....

About your health Please tell us about your health problem(s)

Condition 1 ..... Duration ..... Years ..... Months

Condition 2 ..... Duration ..... Years ..... Months

Condition 3 ..... Duration ..... Years ..... Months

Please give details of how your condition affects your daily life in your present home and surroundings.

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Do you have difficulty walking? Yes ☐ No ☐

If yes do you need any of the following to help you get around

Walking Stick ☐ Tripod ☐ Walking frame ☐ Zimmer ☐ Wheelchair ☐

If you use a wheelchair do you use it indoors or outdoors

Indoors only ☐ Outdoors only ☐ Indoors and outdoors ☐

Are you waiting to be discharged from hospital? Yes ☐ No ☐

Have you been admitted to hospital in the past year? Yes ☐ No ☐

If yes, which hospital, what was the date of admission, length of stay and reason for admission?

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Have you had a community care assessment within the past year? Yes ☐ No ☐

Do you have regular contact/help from Social Work or from another source such as a voluntary agency? Yes ☐ No ☐

If yes provide details of the services you receive

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If you receive Home care / Personal care, please state how often.

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Please give details of the impact of your condition on your family and carers and how this could be improved by a change of house.

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Have you applied for priority on health grounds before? Yes ☐ No ☐

If yes, when did you apply

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Please tell us how your health condition is affected by your housing, and how you feel a move would help.

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About your present home

Is your home A flat ☐ Bungalow ☐ Two or more storey house ☐

If a flat, what floor is it on

Ground Floor ☐ 1st Floor ☐ 2nd Floor ☐ 3rd Floor ☐ 4th Floor ☐ Higher than 4th ☐

Is your property accessible by a lift? Yes ☐ No ☐

How many stairs inside? .....

How many steps outside? .....

Do you have difficulty climbing the stairs in your home? Yes ☐ No ☐

Are there handrails on the stairs? One Side ☐ Both sides ☐ None ☐

If yes, do you use the handrails? Yes ☐ No ☐

How many bedrooms in your home? .....

Are any bedrooms ground floor? Yes ☐ No ☐

Does your bathroom have: A bath only ☐ Shower over bath ☐ Separate shower unit ☐

Level access shower ☐ Wet Floor shower ☐

Do you have any difficulty using your bath or shower? Yes ☐ No ☐

If yes, please describe your difficulty......

.....

Do you have to go upstairs/downstairs to the toilet? Yes ☐ No ☐

Do you have to go upstairs/downstairs to the bathroom / shower? Yes ☐ No ☐

Do you have to go upstairs/downstairs to the bedroom? Yes ☐ No ☐

Do you have any equipment/adaptations to help you? Yes ☐ No ☐

If your home has equipment/adaptations please describe what you have.

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Please describe the type of heating you have

.....

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If your heating is causing health problems please describe them.

.....

.....

Does your home have dampness or condensation? Yes ☐ No ☐

If your home has dampness or condensation please tell us which room the dampness affects and also if the dampness affects your health.

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Do you have difficulty getting to the shops and other places?

Yes ☐ Some difficulty ☐ No ☐

Please tell us what these difficulties are.

.....

Does your illness or disability mean you need an extra bedroom? Yes ☐ No ☐

If yes, please explain why your health condition means that you require an extra bedroom.

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Do you need to stay in your current area to be close to a caring relative or friend? Yes ☐ No ☐

Do you need to move from your current area to be close to a caring relative or friend? Yes ☐ No ☐

Provide the name and address of your caring relative or friend

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Do you have a garden? Yes ☐ No ☐

If yes, what size is your garden? Small ☐ Medium ☐ Large ☐

If not covered by the questions so far please give details of why your accommodation is unsuitable.

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What type of accommodation do you think would be best for you?

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Would you prefer to stay in your present home if it could be adapted? Yes ☐ No ☐

If yes, please tell us why these adaptations cannot be carried out.

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If no, please tell us why

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Obtaining further information

Name of family doctor .....

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Address of family doctor .....

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When was your last GP appointment? .....

.....

Are you attending hospital out patient's clinic? Yes ☐ No ☐

If yes, name of clinic .....

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If you get regular support from anyone else (e.g. Occupational Therapist, Consultant) please provide their name and address.

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Declaration

I give permission for the processing of the personal data information contained in this medical assessment form.

I confirm that the information given on this form is true, and also give my consent for the transfer of relevant information for the purpose of health priority assessment and housing allocation.

I understand that all information will be treated as strictly confidential and only be available to those who need to use it to assess my medical priority.

I am also aware that any medical priority granted may be restricted to certain areas and/or types of property. I am aware that this application and any medical award will be shared amongst the Common Housing Register landlords.

Signed

Date

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