CASTLE POINT HomeChoice

MEDICAL ASSESSMENT FORM

CONFIDENTIAL

For Office Use Only

Applicant Name		App No.	
Date Assessment Sent			

PLEASE READ THE NOTES BELOW BEFORE COMPLETING THIS FORM

Complete this form if either you, or a member of your household who will be housed with you, suffers from ill health, a physical or learning disability or a mental health problem **which is being affected by your current housing.**

- All Medical Assessment Forms are considered by an independent medical advisor.
- Please answer all questions in black ink and in **BLOCK CAPITALS**
- Priority is only awarded **where it is clear that there is a direct link between someone's health problems and their current accommodation**.
- A separate form must be completed for every person named on your housing application form who has a health problem.
- You must complete this form yourself. Please do not ask your doctor to complete it for you. We also need you to provide a copy of your prescription list and recent medical letter / report about your health condition(s) from your doctor, health worker or occupational therapist.
- Please make sure you fill in **ALL** the sections that apply. If you do not, we will return the form to you as your case cannot be assessed properly without full information.

SECTION 1 - Application details

Main Applicant's Name .....

Application Ref (if known) ..... Date of Birth .....

Main Applicant's Address .....

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Tel ..... Email .....

Which member of the household is this information about? (if different from above)

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

Relationship to applicant .....

SECTION 2 - Details of health

Please describe the person's disability or illness

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How long has the person suffered from this illness or disability?

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How does the current property affect the person's condition?

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Why do you feel a move could improve the person's health?

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SECTION 3 - Benefits

Does the person receive any benefit payments related to their illness/disability?

Yes ☐ No ☐

If yes, please state which benefits are received

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SECTION 4 - Current accommodation

What type of accommodation does the person currently occupy?

House ☐ Bungalow ☐ Flat ☐ Bed sit ☐ Maisonette ☐

Room in shared house ☐ Other (please specify) .....

Does the main applicant own the accommodation? Yes ☐ No ☐

Does the person currently live in supported housing? Yes ☐ No ☐

If the accommodation is rented, what type of tenancy is held?

Council ☐ Housing association ☐ Privately rented ☐

Is the tenancy: Secure ☐ Non-secure ☐

How many bedrooms are in the home?.....

If it is a flat, what floor is it on?

Ground ☐ 1st ☐ 2nd ☐ 3rd ☐ Above ☐

Is there a lift? Yes ☐ No ☐

How many people live in the household? aged over 16..... aged under 16.....

Has the home been adapted in any way to meet the person's physical needs?

Yes ☐ No ☐

If yes, please describe the adaptations

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SECTION 5 - Getting around

Does the person have difficulty walking? Yes ☐ No ☐

Does the person have difficulty with your sight? Yes ☐ No ☐

Does the person have difficulty with your hearing? Yes ☐ No ☐

Does the person have difficulty with: (tick all that apply)

Using stairs or steps ☐ Moving about their home ☐ Accessing Public Transport ☐

Using bathroom or toilet ☐ Entering and leaving their home ☐ Using Kitchen ☐

How many stairs is the person able to manage?

None ☐ A few ☐ Up to one flight ☐ More than one flight ☐

Does the person use a walking aid?

At all times ☐ Sometimes ☐ Never ☐

If so what do they use? (tick all that apply)

Sticks	Inside ☐	Outside ☐	Both ☐
Walking Frame	Inside ☐	Outside ☐	Both ☐
Crutches	Inside ☐	Outside ☐	Both ☐

Does the person use a wheelchair?

(tick all that apply) At all times ☐ Sometimes ☐ Never ☐

If so where? Indoors ☐ Outdoors ☐ Both ☐

Is your wheelchair Electric ☐ Manual ☐ Use both types ☐

Describe any difficulties they may have in using or storing it at their current home

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Does the person use a mobility scooter? Yes ☐ No ☐

If yes, is this under the recommendation of a medical practitioner? Yes ☐ No ☐

SECTION 6 - Help received

Does the person currently attend/receive treatment from a hospital? Yes ☐ No ☐

If yes, please give details of all the hospitals where they receive treatment, the department and the name(s) of their consultant/specialist.

Hospital.....Department..... Consultant.....

Hospital.....Department..... Consultant.....

Hospital.....Department..... Consultant.....

Does the person see their GP for regular treatments or check-ups? Yes ☐ No ☐

If yes, please give details including any medication they are being prescribed

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Please give details of the name and address of their GP or surgery/health centre

Name .....

Address .....

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Tel.....Email .....

Are they receiving treatments from a nurse, therapist or other health worker for any physical, sensory or mental health problems? Yes ☐ No ☐

If yes, please give details

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If they have a social worker, please give their name, address and contact details

Name .....

Address .....

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Tel.....Email .....

Does the person receive home care arranged by a social worker? Yes ☐ No ☐

If yes, tell us how often the home carer visits and what service they provide

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Does the person rely on regular help from family or friends? Yes ☐ No ☐

If yes, please give details of who helps them, how often and with what tasks

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You can use the space below to provide any further relevant information

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(Please continue on a separate sheet if necessary)

SECTION 7 - Declaration

I confirm that:

a) **The information given on this form is to the best of my knowledge true and correct. I know I may lose any accommodation offered and could face prosecution if I have knowingly given false or misleading information.**

b) **I agree that the information given on this form may be made available, in confidence, to any relevant individuals or organisations in order that they may be able to assist with this application.**

Signed (Main Applicant)..... Date.....

For further information or help with completing this form, please contact: Tel: **01268 882354** or Email: **HAPPS@castlepoint.gov.uk**

Please return completed forms with copy of prescription list and recent supporting medical evidence to:

HomeChoice Applications
Housing and Communities
Castle Point Borough Council
Council Offices
Kiln Road
Benfleet
Essex SS7 1TF

castlepoint
benfleet | canvey | hadleigh | thundersley

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MEDICAL ADVISORS REPORT

PRIORITY AWARDED: HIGH ☐ MEDIUM ☐ LOW ☐ NONE ☐
EXCEPTIONAL/EMERGENCY STATUS ☐

RECOMMENDED TYPE OF ACCOMMODATION:

REASON FOR NO PRIORITY:

ADDITIONAL COMMENTS:

SIGNED DATED / /