Calvay Housing Association Limited

MEDICAL ASSESSMENT FORM

Please note – Where moving to another home will not alleviate or address a medical problem, no medical points will be awarded.

Where more than one member of the Applicant's moving household has a medical condition that would benefit from rehousing, the member most in need will receive full points and subsequent members of the household will receive 10 points each.

1. Main Housing Applicant's Details

Application Reference Number	
Main Applicant's Name	
Current Address	
Contact Telephone Number	
Date of Birth	

2. Person Applying for Medical Priority (if different from above person)

Name of person applying for Medical Priority	
Date of Birth	
Relationship to Main Applicant	

3. Medical Conditions/Disability that is affected by your current housing situation

Please list all medical conditions or disabilities, medication prescribed and tell us how your current home adversely affects the condition/disability. **If you have any proof of your medical condition/disability, please enclose this.** **You do not need to approach your doctor for confirmation.** **Continue on a separate sheet if necessary.**

Medical Condition/ Disability	Is the condition permanent	Date/Year of Diagnosis	How your current accommodation affects Medical Condition or disability.
	Yes ❑ No ❑		
	Yes ❑ No ❑		
	Yes ❑ No ❑		

4. Rehousing

Please tell us the type/size of property you require and describe how this would help alleviate/resolve your medical/health issues. **Continue on a separate sheet if necessary**

Type/size of Property required:	
How would this help:	

5. Benefits

Are you currently receiving any disability benefits? Yes ❑ No ❑

If yes, please provide details below (and a **copy** of your most recent award letter).

Details of Disability Benefits Received

6. Mobility / Adaptions Info

a) Do you have difficulty walking? Yes ☐ No ☐ If yes, do you use any of the following aids?

	Indoors Only	Outdoors Only	Both Indoors & Outdoors
Walking Stick			
Crutches			
Zimmer Frame			
Wheelchair			
Mobility Scooter			

Other (please specify)

Please explain here how your current housing situation is not helping e.g. you live on a steep hill; you do not live near facilities etc...

b) Do you have trouble climbing stairs? Yes ☐ No ☐

If yes, please answer the following – please note that you will not be considered for properties that have more internal or external stairs than you can manage.

How many stairs can you climb comfortably?	
How many stairs does your current property have Inside?	
How many Stairs does your current property have outside?	

c) Do you have any adaptations in your current property? For example, handrails, bath aids, level access shower, stair lift, ramp etc... Yes ☐ No ☐

If yes, please detail below:

d) What type of bathing facilities do you have?

Bath Only Yes ☐ No ☐ Shower Only Yes ☐ No ☐

Bath with over bath shower Yes ☐ No ☐ Adapted or Wet Floor Bathroom Yes ☐ No ☐

Do you have trouble using your bathing facilities, if so please tell us why?

7. Additional Rooms

How many bedrooms are there in your current home?

Do you require an extra bedroom due to your medical condition? Yes ❑ No ❑

If yes, please tell us why:

8. Other relevant information

Is there anything else you would like to add in support of your application?

DECLARATION AND CONSENT

I certify that the information contained in this medical form is true to the best of my knowledge. I agree to notify you in writing of any change to the information given by me, as this may affect my position on the waiting list.

I understand that any false or misleading information given, or relevant information withheld now or at any time may result in any tenancy granted being terminated or my application being suspended.

I understand that Calvay Housing Association Ltd may make enquiries regarding the information in this form to my Doctor (GP), my hospital Doctor/Consultant, and any other agencies with an interest in my health.

I understand that the information I have provided will be treated as confidential. The information I have provided is covered by up-to-date Data Protection legislation.

Sign in both boxes if you are the medical applicant and the housing applicant.

Housing Applicant's Signature ..... Date .....

Medical Applicant's Signature (if over the age of sixteen and not the Housing Applicant). ..... Date .....

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