MENTAL HEALTH

MEDICAL NEEDS ASSESSMENT FORM

Guidance for completing this form

If you think that your current home or housing circumstances are impacting on your mental health, please complete this form.

You should complete all sections, providing as much information as you can. Ensure that you demonstrate how your medical condition(s) would be improved by a move.

If you require any help or support in completing the form, then please contact the Choice Move Team on 01246 217670.

This form is only valid if you have submitted a Housing Application Form.

Please DO NOT complete the form if any of the following apply;

- Your illness is related to a pregnancy and will be resolved once the baby is born
- You are in overcrowded accommodation – this will be assessed separately using information from your housing application
- Your property is in disrepair – if you are renting the property you will need to contact your current landlord and report these issues
- You are requesting medical priority due to receiving support, if this is the case please request a Support Needs Assessment Form

Once you have submitted this form it will be assessed by an Allocations Officer in the Choice Move Team.

If necessary, a home visit will be conducted by Rykneld Homes to obtain further information or discuss your circumstances further. However, if you live outside of the North East Derbyshire District Council area, this may not be possible.

You will need to provide detailed supporting letters from a GP or mental health professional confirming any medical diagnosis, medication prescribed and confirmation that your health is deteriorating as a sole and direct result of your housing circumstances. **We will be unable to consider your medical needs assessment form without clear evidence of significant health improvement if re-housed**.

Office Use Only. **Name:** **Application Number:**

Section A - Personal Details

Please complete the details for the person applying for medical priority – *this may be the applicant or occupant*

First Name:

Last Name:

Date of Birth:

Address:

Contact Details:

Home phone:

Mobile Phone:

Relative:

Relative's name/relationship:

Section B – Your current accommodation

Please provide the following details for the property you currently live in

What type of property do you currently live in:

House ☐ Bedsit/Studio ☐ Hostel ☐

Bungalow ☐ Ground Floor Flat ☐ Caravan ☐

Upper Floor Flat ☐ Other (please specify) _____

Is the applicant currently in hospital? Yes ☐ No ☐

Please give details including the name of hospital, admission date, reason for admission and possible discharge date.

What is your current tenure type:

Owner ☐ Lodger (friends/family) ☐ Homeless/NFA ☐

Housing Association ☐ Other Local Authority ☐ Private Tenancy ☐

Armed Forces ☐ Other (please specify) _____

How many bedrooms do you have?

Please provide details of occupants at your current address.				
Name	**Date of Birth**	**Gender**	**Relationship to applicant**	**Moving with applicant?**

What are the sleeping arrangements in your current accommodation?

Bedroom 1:……. Bedroom 2:…….

Bedroom 3:……. Bedroom 4:…….

Other:……
……
……
……
……

If children/a couple within your current household sleep separately due to their own medical conditions, please provide evidence of this.

Section C – Your Medical Needs

Please provide as much information as possible regarding your health

Please describe your medical conditions:

How does your current home affect your medical conditions? Please advise in as much detail as possible, please use further sheets if needed.

Have any preventative measures been implemented to resolve your housing need (e.g. reports to the Landlord, reports to the Police, alterations to property)? If yes, please describe.

What medication do you take for your medical condition?

Please give the name of medication, strength and how often it is taken.

Please advise what support is currently in place, who by (which agencies e.g. CPN/Mental Health Team/Rethink, etc) and how frequently you are in receipt of support:

Do you receive any of the following benefits for your ill health/disability?

Disability Living Allowance ☐ Carer's Allowance ☐
Personal Independence Payment (PIP) ☐
Attendance Allowance ☐
Incapacity Benefit/ESA ☐
Statutory Sick Pay ☐

Can you carry out the following tasks unaided?

Cooking ☐ Shopping ☐ Dressing ☐
Cleaning ☐ Bathing ☐ Toileting ☐

If you cannot carry out any of these tasks, details of help you receive or will need:

Do you have any problems accessing local shops/services?

Yes ☐ No ☐ If yes, please describe:

Do you have access to a car?

Yes ☐ No ☐
Do you have a blue badge?
Yes ☐ No ☐

Do you use public transport?

Yes ☐ No ☐

Do you have a warden service?

Yes ☐
No ☐

Have you had, or are awaiting, a Social Care assessment?
Yes ☐ No ☐ If yes, please explain:

Please give any further details regarding your medical conditions and how this affects your daily life:

Section D – Your New Home

Please provide details on the type of accommodation that would suit your needs

What property would best meet your needs?

Bungalow ☐ House ☐ Bedsit/studio ☐

Ground floor flat ☐ Upper floor flat ☐

How many bedrooms do you need?

1 ☐ 2 ☐

3 ☐ 4+ ☐

If you require an extra bedroom please explain why:

Do you have an overnight carer? Yes ☐ No ☐

Details – who, how many nights per week and sleeping or waking carer?

If overnight, when did you start receiving overnight care? How long is this expected?

Do you require to be re-housed in a specific village of North East Derbyshire?

Yes ☐ No ☐

If yes, area:

Reasons:

Section E – Your Doctor/Consultant

Please provide details of your current medical support

Doctors Name:

Surgery Address:

When did you last see your GP?

Do you receive help from a support worker, district nurse or home help?

Yes ☐ No ☐

Details:

Do you regularly attend a clinic or hospital?

Yes ☐ No ☐ Details:

Please provide any other details you think are relevant for your Medical Needs Assessment:

Section F – Declaration

Please read and sign below to give your consent for us to process your medical form

I confirm that all the information given on this form is correct and complete to the best of my knowledge.

I give my permission for Rykneld Homes to contact any relevant individual, organisation or agency to obtain information that may be relevant to my application, including information from my Doctor, Consultant or Social Services, if necessary.

I give my permission for the above information to be assessed by Rykneld Homes and where necessary a home visit arranged. I acknowledge that this information will be held by Rykneld Homes for the purpose of my housing application.

Please note that Rykneld Homes will not be responsible for any charges incurred for supporting evidence and there is no guarantee that priority will be awarded from any evidence supplied.

Please note, the person applying for medical priority should sign this form unless they are;

- Under the age of 16 – in this case a parent or person with parental responsibility should sign for them
- The person signing has Power of Attorney for the applicant. Please provide RHL with a copy of the Power of Attorney, if you have not already done so.

Signature:	Date:

Please ensure supporting medical evidence is provided with your request for medical priority.

If anyone other than the applicant has completed and/or signed this form, please provide details below;

Name of person completing form:
Relationship to applicant/Agency:
Contact Number:

Signature:	Date: