MEDICAL NEEDS ASSESSMENT FORM

Guidance for completing this form

Please note this form will only be accepted if you have submitted a housing application form or are submitting a housing application along with this assessment form.

If you think that your current home is unsuitable due to your medical or mobility needs please complete this form. You should complete all sections, providing as much information as you can. Ensure that you demonstrate how your medical condition **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.

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

- Your illness/injury is related to a pregnancy and will be resolved once the baby is born
- The illness/injury will get better with treatment (e.g. broken arm)
- You are in overcrowded accommodation – this will be assessed separately using information from your housing application
- You have a minor illness (e.g. cold, flu)
- Your property is in disrepair – if you are renting the property you will need to contact your current landlord and report these issues
- You have a temporary need for adapted accommodation (your illness/injury will improve with time/medication/medical support)

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

If necessary, a home visit may be arranged by Rykneld Homes to assess your medical situation in your current home. You may be asked to display your capability to undertake certain household tasks, for example accessing your home, climbing the stairs or getting in and out of a bath.

Please be aware, we may not be able to visit your home if you live outside of the North East Derbyshire District Council area.

You will need to provide a Patient Summary from your GP to support this assessment.

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:

Height:

Weight:

Section B – Occupants of Present Accommodation

Please complete the details for any person living with you currently

Name	Date of Birth	Gender	Relationship to applicant	Moving with applicant?

Is the person currently in hospital? Yes ☐ No ☐

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

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Section C – 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 ☐

How many bedrooms do you have?

How many steps are there inside your property?

How many steps are there outside your property?

Do you have a ramp or handrails to assist you? Yes ☐ No ☐

If yes, which adaptations do you have?

What parking facilities do you have?

Driveway/offroad parking ☐ Communal Car Park ☐

On street parking ☐ Other ☐

What bathing facilities do you have?

Bath ☐ Wet room/level access shower ☐

Shower cubicle ☐ Shower over bath ☐

Other ☐

Do you have difficulty using your current bathing facility?

Yes ☐ No ☐ If yes, explain why:

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

Do you have difficulty climbing the stairs? Yes ☐ No ☐

If yes, how many steps can you easily manage?

Do you use any of the following?

Walking stick/crutches ☐
Walking Frame ☐
Wheelchair ☐
Wheeled walker ☐
Toilet Frame ☐
Bath Board/seat ☐

Do you have a lift in your property?

Stairlift ☐
Through floor ☐
Communal lift ☐

If you have a wheelchair, do you use it indoors, outdoors or both?

Indoors ☐ Outdoors ☐ Both ☐

Is the wheelchair self-purchased or a prescription?

What type of heating do you have in your current property?

Gas ☐ Solid Fuel ☐ Electric ☐ Other ☐

Do you have problems with the heating in your home? Yes ☐ No ☐

If yes, please explain

Where do you currently sleep?

Upstairs ☐
Downstairs ☐
If downstairs, which room?

What toilet facilities do you have?

Upstairs WC ☐
Downstairs WC ☐
Outside WC ☐

What adaptations does your current home have?

Stairlift ☐ Ramp ☐ Ground Floor WC ☐
Wet Room ☐ Hand Rails ☐ Stair Rails (how many) ☐
Other ☐

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

Do you use other equipment to help you mobilise in your home?

Section D – 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?

What medication do you take for your medical condition?

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

Do you receive any of the following benefits?

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	☐

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

If you cannot carry out the tasks unaided, please give details of the help you currently receive or the help you will need?

Do you have access to a car?	Do you have access to a mobility scooter?	Do you use public transport?
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you have a blue badge?		
Yes ☐ No ☐		

What distance are you able to walk?

Inside home only ☐ A very short distance outside ☐
A moderate distance outside ☐ More than ¼ mile outside ☐

Do you have any problems accessing local shops/services?

Yes ☐ No ☐ If yes, please describe:

Do you have difficulty walking up hill?

Yes ☐
No ☐

Do you have a warden service?

Yes ☐
No ☐

Have you had any falls recently?

Yes ☐ No ☐

If yes, when was your last fall and how did this affect your health?

What medical treatment did you receive?

Have you had, or are awaiting, a Social Care assessment?

Yes ☐ No ☐ If yes, please explain:

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

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

Section E – 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?

What adaptations do you feel you require in your new property, if any?

Stairlift ☐ Wet Room ☐ Wheelchair Access ☐ Ground Floor ☐

Ramped Access ☐ Sheltered Accommodation ☐ Other ☐

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Section F –

GP and hospital details, further information.

Doctors Name:

Surgery Address:

When did you last see your GP?

Do you receive help from a district nurse or home help?

Yes ☐ No ☐ Details:

Do you regularly attend a clinic or hospital?

Yes ☐ No ☐ Details:

Please provide any other relevant details for your Medical Needs Assessment

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Section G – 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 Ltd (RHL) to contact any relevant individual or organisation/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 you have enclosed a copy of your Patient Summary from your GP. No assessment can be undertaken without supporting evidence.

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:	
Signature:	Date:

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