**MEDICAL APPLICATION FORM - CONFIDENTIAL**

This form is to help us decide whether you should have any priority on the housing register on medical grounds. Our assessment is based on how your current accommodation affects your health and we may also make a recommendation on your future needs.

A SEPARATE form should be completed for EACH person who wants to apply for a medical assessment.

Please provide any additional information you may think may help, i.e. GP letter, OT report. If you decide to obtain additional evidence, this will be at your own expense. The Council may also contact your GP directly if necessary.

Please answer all questions fully as incomplete forms may not provide us with enough information to make an assessment. All information given will be treated confidentially.

Medical priority will not be given for (amongst other things); pregnancy, overcrowding, minor illnesses (such as colds or flu), or any other conditions/temporary disability such as a broken limb.

**Please do not submit another form once the assessment has been made unless your medical condition changes. Applications will not normally be re-assessed within 6 months unless there has been a marked deterioration in the applicant’s health.**

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| **ABOUT YOU** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.** **Name of the person with the medical need to move** **:** Mr Mrs Ms Miss Master | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2. First name:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **3. Surname/Family name:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
| **4. Present address:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | | | | |  | | | | | | | | | | | | | | | | **Post code:** | | | | |  | | | | |  |
| **5. Date of birth:** | | |  | | | | | | | | | | | | | | **6. Gender:** | | | | Male Female | | | | | | | | | | |  |
| **7. Housing Register Application Number:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| **8. Do you live in a:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| House |  | | | | Maisonette | | | | | | |  | | | | Self Contained Annexe/ B&B | | | | | | | | | | |  | | | | | |
| Bungalow |  | | | | Flat | | | | | | |  | | | | Bedsit with shared facilities | | | | | | | | | | |  | | | | | |
| **9. No of bedrooms :** 0 1 2 3 4 5 6 or more | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **10. Do you share any part of your home with anyone OTHER than your family?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes No | | | | |
| **11. If you said yes to the above question – which parts of your home do you share?**  Bathroom Toilet Kitchen Bedroom Hallway Living Room | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **12. Who do you share with?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name :** | | | | | | | | | | | | | | **Relationship to you :** | | | | | | | | | | | | | | | | | | |
| **13. If you are in a flat or maisonette which floor is your front door on? (please choose one)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **14. How many steps are there to the front door of your home?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Outside:** | | | | | | | | | | | | | | **Inside:** | | | | | | | | | | | | | | | | | | |
| **15. Is there a lift ?** Yes No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **16. On which floor is your bathroom?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **17. On which floor is your toilet?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **18. On which floor is your additional toilet ( if you have one)?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **19. On which floor is your bedroom on?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **20. On which floor is your living room?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basement Ground 1 2 3 4 Other (please state): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **21. How is your living room heated?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gas central heating | | | | | | |  | | | Gas fire | | | | | | | | | |  | | | | | Warm/Blow air | | | |  | | | |
| Underfloor | | | | | | |  | | | Electric fire | | | | | | | | | |  | | | | | Electric storage | | | |  | | | |
| None or other type | | | | | | | please specify | | | |  | | | | | | | | | | | | | | | | | | | |  | |
| **22. Have any adaptations been provided in your current home to help your household manage in it?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialist Bath | | | |  | | | | Adapted WC | | | | |  | | Adapted Kitchen | | | | | | | |  | | | Standing Crossover | | | |  | | |
| Through floor lift | | | |  | | | | Stair lift | | | | |  | | Grab Rails | | | | | | | |  | | | Hoist Bathroom | | | |  | | |
| Hoist Bedroom | | | |  | | | | Hoist L/Room | | | | |  | | Hoist WC | | | | | | | |  | | | External Rail | | | |  | | |
| Step in Shower Tray | | | |  | | | | Key Safe | | | | |  | | Lever Taps | | | | | | | |  | | | Low Level Switches | | | |  | | |
| Parking Bay | | | |  | | | | Car Port | | | | |  | | Ramp Access | | | | | | | |  | | | Integral Garage | | | |  | | |
| Shower Over Bath | | | |  | | | | Doorbell for hearing impaired | | | | |  | | Graduated Floor Shower | | | | | | | |  | | |  | | | |  | | |
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| Other (please describe) | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **23. Are you registered disabled?** | | | | | | | | | | | | | | | | | Yes | | | | | | | No | | | | | | | | |
| **24 .Do you use a wheelchair?** | | | | | | | | | | | | | | | | | Yes | | | | | | | No | | | | | | | | |
| If yes to the previous question – **When do you need to use your wheelchair?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. All the time (indoors and outdoors) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 2. Some of the time, usually outdoors | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 3. Other, please explain | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| **25. Can you walk upstairs? (choose one)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I do not have a problem with steps or stairs | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Stairs are difficult for me, I can manage one or two steps | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| I cannot manage steps or stairs at all | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| **ABOUT YOUR MEDICAL CONDITION** | | | | | | | | | | | | |
| **26. Name and brief description of your illness or disability** | | | | | | | | | | | | |
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| **The following question will help us to make an assessment on your application. If you are not able to give us a full description, we will not be able to assess you. Please note, we do not give medical priority because you are overcrowded and have no space as this attracts its own priority** | | | | | | | | | | | |  |
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| **27. How does your current home affect your health?** | | | | | | | | | | | |  |
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| **28. If you are currently receiving any treatment or medication, please give details** | | | | | | | | | | | | |
| **Name of Treatment/Medication/Therapy** | | | | **Amount Taken/Dose** | | | | **How Often** | | | **When Started** | |
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|  | **29. Please describe the history of your condition** (e.g. has it got better or worse, does is come and go?) | | | | | | | | | | |  |
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| **30. Please give full name and address of your General Practitioner (family doctor):** | | | | | | | | | | | |  |
| Doctor (GP): | |  | | | | Tel No: | | |  | | | |
| Address: | | | | | | | | | | | | |
| Post Code | |  | | | | | | | | | | |
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| **ABOUT HOSPITAL/CLINICAL APPOINTMENTS** | | | | | | | | | | | | |
| **31. Please give details of all the professionals (i.e. clinics, therapists, consultants and specialists) you are currently registered with or have seen within the past year about the medical condition(s) you have described.** | | | | | | | | | | | |  |
| **Service No 1:** | | | | | | | | | | | | |
| Last date visited : | | | | | | | | | | | | |
| Surname : | | |  | | | | First Name : | | |  | | |
| Address : | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Post Code : : | | |  | | Tel No : | | | | |  | | |
| **Service No 2:** | | | | | | | | | | | | |
| Last date visited : | | | | | | | | | | | | |
| Surname : | | |  | | | | First Name : | | |  | | |
| Address : | | |  | | | | | | | | | |
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| Post Code : : | | |  | | Tel No : | | | | |  | | |
| **Service No 3:** | | | | | | | | | | | | |
| Last date visited **:** | | | | | | | | | | | | |
| Surname : | | |  | | | | First Name : | | |  | | |
| Address : | | |  | | | | | | | | | |
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| Post Code : : | | |  | | Tel No : | | | | |  | | |
| **Service No 4:** | | | | | | | | | | | | |
| Last date visited : | | | | | | | | | | | | |
| Surname : | | |  | | | | First Name : | | |  | | |
| Address : | | |  | | | | | | | | | |
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| Post Code : : | | |  | | Tel No : | | | | |  | | |

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| **ABOUT HOSPITAL ADMISSIONS** | | | | |
| **32. Please give details of any hospital admissions relevant to the medical condition you have described :** | | | | |
| **Hospital No 1 Name** : | | | | |
| Hospital Location : | | | | |
| Reason for Admission : | | | | |
| Date Admitted: Month | Year | | | |
| Length of stay (please circle which applies) No of Days/Weeks/Months/Years | | | Number: | |
| Your hospital reference number : |  | | | |
|  | | | | |
| **Hospital No 2 Name** : | | | | |
| Hospital Location : | | | | |
| Reason for Admission : | | | | |
| Date Admitted: Month |  | Year | |  |
| Length of stay (please circle which applies) No of Days/Weeks/Months/Years | | | Number: | |
| Your hospital reference number : |  | | | |
|  | | | | |
| **Hospital No 3 Name** : | | | | |
| Hospital Location : | | | | |
| Reason for Admission : | | | | |
| Date Admitted: Month |  | Year | |  |
| Length of stay (please circle which applies) No of Days/Weeks/Months/Years | | | Number: | |
| Your hospital reference number : |  | | | |

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| **Declaration of Truth** | | | | | | |
| **I certify that the information I have given on this form is true and correct to the best of my knowledge. I understand that knowingly making false statements could give the Council grounds for deferring, cancelling or amending my housing registration or for prosecuting me. I also understand that I could lose any tenancy granted as a result of my giving false information.**  **By submitting this form I agree that I will notify the Council of any changes in my circumstances that affect the details I have given on it. If you do not give this office the full facts or you deliberately give false information or do not tell this office of any important changes in your situation between your first contact with the Council and the time that a decision is about your case is made, you may be breaking the law as set out in Section 214 of the Housing Act 2002. Anyone doing so may be prosecuted by the Council and if found guilty may be ordered to pay a fine of not more than £5,000.**  **The information you provide will only be used in connection with your application for housing assistance, providing you with necessary services, prevention of fraud (see next paragraph) and for statistical purposes. Your personal information will be shared with other Council departments for the same purposes only. All information will be treated as confidential and will be held and processed in accordance with the Data Protection Act 1998. The Data Controller is the London Borough of Newham and the nominated representative is the Information Steward.**  **This Authority is under a duty to protect the public funds it administers, and to this end may use the information on this form and the Housing Registration/Housing Options Form within this Authority for the prevention and detection of fraud. It may also share this information with other bodies administering public funds.** | | | | | | |
| Name: |  | | | | (please print your full name) |  |
|  |  | |  | |  |  |
| Signature: |  | | Date: | |  |  |
| **If you are completing this form on behalf of someone, please give your details below:** | | | | | | |
| Name: |  | | | (please print your full name) | |  |
|  |  | | | | |  |
| Address: |  | | | | |  |
|  | |  | | | |  |
| Relationship to the applicant: | |  | | | |  |
|  |  | |  | |  |  |
| Signature: |  | | Date: | |  |  |
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| **Authority to Obtain Medical Information** | | | | | | |
| **We may need to write to your Doctor, Social Worker or Therapist for more information. We cannot do this without your consent. Please complete the declaration fully (e.g. name, address, signature, date).** | | | | | | |
| DECLARATION I authorise my Doctor/Social Worker/Therapist (or the Doctor/Social Worker/Therapist of my child who is under 16) to disclose information about my physical and/or mental health to the Council’s Medical Adviser to assist with my application for housing. | | | | | | |
| Name: |  | | | (please print your full name) | |  |
|  |  | | | | |  |
| Address: |  | | | | |  |
|  |  | | | | |  |
| Signature: |  | | Date: | |  |  |
|  |  | |  | |  |  |