MEDICAL NEEDS ASSESSMENT FORM

Guidance for completing this form

If you believe your current home is unsuitable for your physical medical or mobility needs then please complete this form.

You must complete all sections of the form, providing as much detail as possible. Ensure that you give as much information as you can on how your situation could be improved by a move to another property type.

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

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

- Your illness or injury is related to pregnancy and will be resolved once the baby is born.
- The illness or injury will get better with treatment (e.g. a broken bone).
- You are in overcrowded accommodation – this will be assessed in accordance with criteria within the Choice Based Lettings Policy.
- Your property is in disrepair – if you are privately renting, you will need to contact your landlord or Environmental Health to report this.
- You have a temporary need for adapted accommodation (your illness or injury will improve with time/medication/medical support).
- You do not currently live in, or have a local connection to, the Bassetlaw District Council area.
- You moved into the property with pre-existing medical conditions which deem it unsuitable.

Once you have submitted a completed form and evidence required it will be assessed by Bassetlaw District Council's Housing Registrations Team in accordance with the Choice Based Lettings Policy. If deemed necessary, you will be referred to the Medical Panel for consideration of banding and property type recommendation.

Before submitting this form you will need to contact Nottinghamshire County Council for an Occupational Therapy assessment to support further detail of your re-housing needs – they can be contacted on 0300 500 8080. You can also provide any additional supporting letters from professionals or agencies involved with you.

For this application to be considered you must provide a Patient Summary Record from your GP surgery and an Occupational Therapy report.

Incomplete forms will be returned to you.

Section A – Personal Details

Please complete the below details for the person applying for medical priority.

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Please specify	**First Name:**
Surname:	**Date of birth:**

Address:	**Postcode:**
When did you move to this address	

Did you have your current medical conditions when you moved into the above address?	Yes ☐ No ☐
If you answered yes above, please give detail on why you moved into the property if it was unsuitable for your medical needs;	

Contact Details	
Home Phone	
Mobile Phone	
Email	

Section B – Persons living with you/moving with you

Name	Date of birth/age	Gender	Relationship to you	Is this person moving with you
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

Section C – Your Current Accommodation

Please provide details of the property you currently live in

What kind of property do you live in currently?

House ☐ Bungalow ☐ Bedsit ☐

Ground floor flat ☐ Caravan ☐ Hostel ☐

Upper Floor Flat ☐ Maisonette ☐
What floor level …….

Other ☐ Please specify -

What is your current tenure type?

Bassetlaw tenant ☐ Other council tenant ☐
Housing association ☐ Private tenant ☐ Owner Occupier ☐
Family/friends ☐ Lodger ☐ Tied tenancy ☐

Other ☐ please specify -

How many bedrooms do you have?	
Where is the toilet in your property?	Downstairs ☐ Upstairs ☐ Both ☐
What bathing facility do you have?	Bath only ☐ Shower over bath ☐ Level access shower/wet room ☐ Shower tray/cubicle ☐ Other ☐ Please describe;

How many steps do you have outside your home? Include steps from the pavement to your entrance door.	
What parking facilities do you have?	Driveway ☐ Car park ☐ On road ☐ No parking ☐
Do you have a ramp to your door?	Yes ☐ No ☐

Do you have difficulty managing stairs?	Yes ☐ No ☐
If you answered no, please go to the next question.	
How many steps/stairs are there inside your current home? Including stairs and any internal steps to rooms.	
How many steps could you easily manage?	None ☐ 1-2 ☐ 3-5 ☐ More than 5 ☐ Other ☐ please specify –

Do you have difficulty bathing?	Yes ☐ No ☐
If no, please go to the next question.	
Please describe what difficulties you have with your current bathing facilities	

What aids/adaptations do you currently have? Please tick all that apply.		
Stair lift ☐	Wet room ☐	Ramp ☐
Handrails ☐	Second stair rail ☐	Lift ☐
Walking stick/crutches ☐	Walking frame ☐	Wheeled walker ☐
Toilet frame ☐	Bath board/seat ☐	Commode ☐
Other ☐ Please specify -		

Do you use a wheelchair	Yes ☐ No ☐
If yes, is this prescribed or self-purchased?	Prescribed by a medical professional ☐ Self-purchased ☐
Do you use your wheelchair indoors or outdoors?	Indoors only ☐ Outdoors only ☐ Both ☐

Section D – Your Medical Needs

Please describe your diagnosed medical conditions.

Please advise what medication you are currently prescribed. Please give the name of the medication and the dosage.

How do your medical conditions make it difficult to manage your current home? Please give as much information as possible about what you can't manage in your home.

Do you require regular assistance to do the following tasks? Please tick all that apply		
Getting dressed ☐	Cooking ☐	Cleaning ☐
Bathing ☐	Toileting ☐	Shopping ☐
Taking medication ☐	Attending appointments ☐	

Do you receive any of the following benefits? Please tick all that apply	
Incapacity/ESA ☐	Statutory sick pay ☐
Attendance allowance ☐	Disability Living Allowance ☐
Personal Independence Payment ☐	
Does anyone receive Carer's Allowance to care for you?	Yes ☐ No ☐
Please confirm who receives this and their relationship to you.	

Please confirm your mobility details	
How far can you walk?	Cannot walk independently ☐ Inside only ☐ A very short distance outside ☐ A moderate distance outside ☐ More than ¼ of a mile ☐
Do you have a car?	Yes ☐ No ☐
Do you have a mobility scooter?	Yes ☐ No ☐

Have you had any falls recently?	Yes ☐ No ☐
If yes, when was your last fall? **What medical treatment did you receive?**	
Do you have a warden alarm service?	Yes ☐ No ☐

Section E – Your New Home

Please provide details on what kind of home would meet your medical needs.

What type of property do you think would best meet your needs?		
Bungalow ☐	Ground Floor Flat ☐	Adapted House ☐
Upper Floor Flat ☐	House ☐	

How many bedrooms do you require?	
Do you have a regular overnight carer?	Yes ☐ No ☐
If yes, how often is this overnight care required & who is it provided by?	

What adaptations would you require in a new property? Please tick all that apply		
Stair lift ☐	Wet room ☐	Ramp ☐
Wheelchair access ☐	Ground floor WC ☐	No steps ☐
Handrails ☐	Second stair rail ☐	Lift ☐

Section F – Your Medical Professional(s)

Your GP's name	
GP surgery address	
When did you last see your GP?	
Do you receive any daily paid care? Provide company name & details of care provided.	
Do you attend any regular hospital clinics? Please provide details of what clinic, for which condition & how often.	
Do you see a Consultant? Please provide name & for which condition.	Yes ☐ No ☐
When did you last see your consultant?	

Do you have any other professionals working with you?	
Yes ☐ No ☐	
Name of worker(s):	
Agency worked for:	
How often do you have contact with this worker?	

Please give any other detail relevant for your medical assessment

Section G - Declaration

Please read and sign to give your permission for us to process this form.

I confirm that all information I have given within this form is correct to the best of my knowledge.

I give permission to Bassetlaw District Council to contact any relevant individual or agencies to obtain information which will support my medical needs assessment form.

I understand that if a tenancy is allocated to me on the basis of the information provided within this form and this is false, legal action may be taken against myself and/or the tenancy.

The data collected in this form will only be used for the purpose of assessing your medical need for rehousing and will only be held for the period within the Bassetlaw District Council retention policy. This data may be shared with third parties such as those detailed above DP No Z5609066. For more information, view our Privacy Policy at www.bassetlaw.gov.uk/privacy.

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

- *They are under 16 years old – in this case a person with parental responsibility should sign for them.*
- *The person signing has Power of Attorney (POA) for the applicant. Please provide a copy of the relevant POA with this form.*

Signature:	
Print Name:	
Date:	

Please ensure the relevant supporting evidence required is provided with this medical form.

This must be a Patient Summary from your GP and an Occupational Therapy report from Nottinghamshire County Council.

Applications provided without this evidence will be returned.