MENTAL HEALTH MEDICAL NEEDS ASSESSMENT FORM

Guidance for completing this form

If you believe your current home is unsuitable for your mental health 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.

Please DO NOT complete this form if the following apply;

- Your mental health is related to a temporary situation.
- You are living in an overcrowded situation – this will be assessed separately with the information in your housing application.
- Your property is in disrepair – if you are renting your property, you need to contact your landlord to discuss these issues.
- You are requesting medical priority due to supporting someone – if this is the case please speak to the Housing Registrations Team for advice.

When you submit this form, and the relevant supporting evidence, it will be assessed for submitting to the Medical Panel.
If the information you have provided does not meet the criteria for the medical panel you will be advised of this at the earliest opportunity.

For your mental health needs to be considered, you will need to provide a detailed supporting letter from a Medical Professional which outlines;

- Your diagnosed medical conditions.
- Prescribed medication/ongoing treatment.
- Reasons your mental health is directly affected by your housing situation.
- How a move would significantly improve your mental health.

Your Mental Health Medical Needs Assessment Form will not be considered without a detailed letter outlining the above. If your form is submitted without this evidence it 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	

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 ☐

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 in your current property?	

What are the current sleeping arrangements in your household?

Please list which household members sleep in which rooms;

Bedroom 1 ……. Bedroom 2 …….

Bedroom 3 ……. Bedroom 4 …….

Other (please detail) …….

……..

……..

……..

If your children require separate bedrooms due to their own medical conditions, you will need to provide evidence of this from a medical professional which details their diagnosed conditions and reasoning for requiring their own bedroom.

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 how your mental health is directly affected by your housing situation.

Have any preventative measures been implemented to resolve your housing needs?
For example, reports to your landlord or Police, alterations to the property, additional security.

Please describe what support you currently have in place for your mental health.
For example – GP, specialist mental health team/CPN, support agencies, family/friends. Please explain what support is provided and how often.

Do you receive any of the following benefits for your mental health?
Please tick all that apply

Incapacity/ESA ☐ Statutory sick pay ☐
Attendance allowance ☐ Disability Living Allowance ☐
Personal Independence Payment ☐

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 have difficulty accessing local shops/facilities?

Yes ☐ No ☐

Please detail why –

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

Yes ☐ No ☐

Please detail –

Do you require any overnight care for your mental health?

Yes ☐ No ☐

Please detail who provides this and how often it is required –

Please give any other detail you think relevant for your medical assessment

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 ☐

Please explain your reasons for this;

Do you require re-housing in a specific area of Bassetlaw?

Yes ☐ No ☐

Which area –

Please provide your reasons for needing this specific area –

Do you have a car?	Yes ☐ No ☐
Do you use public transport?	Yes ☐ No ☐
Do you regularly require support in person at unsocial hours of the day?	Yes ☐ No ☐ If yes, please provide details including who provides this support & how often.

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?	

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 mental health medical form.

This must be a detailed supporting letter from a medical professional which gives the required information noted in the guidance section of this form.
Applications provided without this evidence will be returned.