

Please return to

The Housing Advice Team, Wyre Forest House, Finepoint Way, Kidderminster,
Worcestershire, DY11 7WF

Health & Disability Assessment



Date Rec'd
Ref No

Name of Applicant	
Name of Other Applicant	

Full name of person(s) included in your application with medical condition

Name	D.O.B.	Disability/Medical Condition (Please continue on a separate piece of paper if necessary)

Address	Tel No
Address	Tel No

Name	What Medication do you take? (Please continue on a separate piece of paper if necessary)	Indicate Dosage

How does your housing affect your medical condition/disability?

Name	How are you affected?

Do you get any of the following?

(Please tick where applicable)

Mobility Allowance

Yes No

Name _____

Disability Living /Attendance Allowance

Yes No

Severe Disablement Allowance

Yes No

Other (Please describe in the box below)

Yes No

Are you Registered Disabled?

Yes No

If Yes, who? Name _____

Do you have a:

Community alarm system, telecare or careline telephone?

Yes No

Warden alarm system, i.e. Resident warden on site?

Yes No

YOUR HOME

Do you live in

(Please tick one)

A house (all)

Yes No

A house (downstairs only)

Yes No

A bungalow

Yes No

A ground floor flat

Yes No

An upstairs flat (which floor)

Yes No Floor No.....

If Yes, is there a lift

Yes No

Other, (Please describe in the box below)

Yes No

Does your home have any special aids/adaptations? If yes, please give details

Mobility

Can you get around inside your home?

- Easily
- With difficulty
- Not at all

Do you use any of the following inside your home?

- Walking stick
- Walking frame
- Wheelchair

Do you have difficulty climbing stairs in your property? Yes No N/A

Do you need to go upstairs to access your toilet, bathroom or bedroom? Yes No

Can you get around outside your home?

- Easily
- With difficulty
- Not at all

Do you use any of the following outside your home?

- Walking stick
- Walking frame
- Wheelchair

Do you have problems with?

- Sight?
- Memory?
- Hearing?

What type of accommodation would help your medical need/disability?

How would this accommodation help your medical need/disability?

Any other information relevant to medical need

Name and Address of GP(s)

Name and Address of Specialist

Authorisation to Disclose Information

I/We understand that 'Home Choice Plus' may share information provided with other organisations and statutory bodies to meet my/our housing needs and to protect public funds. I/We understand 'Home Choice Plus' will make enquiries which are appropriate and relevant to this medical and disability form.

'Home Choice Plus' is a partnership of six local authorities, Bromsgrove, Malvern Hills, Stratford, Worcester, Wychavon and Wyre Forest, working together for the purpose of prioritising the allocation of social housing. The legal basis for processing data is under the Council's public task as set out in part 6 and part 7 of the Housing Act 1996, as amended.

The information provided on this form will be held on computer and is subject to the provisions of Data Protection legislation. The information is confidential and will not be passed on to any other person or organisation without your consent unless required to do so by law for the purposes of housing. For further information on 'Home Choice Plus', data protection policy and procedures please contact the agency dealing with your application or see the privacy policy on the Home Choice Plus website. Your information will be stored for a period of 6 years from the closure of your application.

(A Parent should sign for those under 18)

Signature of Patient 1		Date	
Signature of Patient 2		Date	

