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 three local authorities, Bromsgrove, Stratford 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.

Please see the Privacy Policy on the Home Choice Plus website for further information about how we store and use your data.

(A parent should sign for those under 18)

Signature of Patient 1		**Date**	
Signature of Patient 2		**Date**	

FOR OFFICE USE ONLY

HOUSING ASSESSMENT

No medical need Gold Plus Silver Plus

Referral: Yes No Date:

Comments

Medical referee's assessment

No medical need Medical Need

Banding decision

No medical need Gold Plus Silver Plus

Housing Manager's Signature **Date**