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| --- |
| **Official Use Only** |
| Date Received: | Reference No: |
| Internal Transfer?(tick) |

**1 Cressy Street, Linthouse, Glasgow G51 4RB**

[**www.linthouseha.com**](http://www.linthouseha.com)



**Housing Application: Medical Assessment Form**

**DETAILS**

|  |  |
| --- | --- |
| Name of Applicants |  |
| Reference No. |  |
| Address |  |
| Name of person with medical condition (if different from above) |  | Date of Birth |  |

**YOUR MEDICAL CONDITION/IMPAIRMENT**

|  |
| --- |
| Please use the space below to describe the nature of your health problem(s) |
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**LINTHOUSE HOUSING ASSOCIAITON IS A CHARITY REGISTERED IN SCOTLAND – SC028161**

**YOUR CURRENT HOME & YOUR MEDICAL CONDITION/IMPAIRMENT**

What type of property do you live in:

Multi Storey 🞏 Tenement 🞏 Maisonette 🞏 Terraced 🞏 Other 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Which floor do you live on? |  |  |
| Are there any steps to your front door? |  Yes 🞏 How many? \_\_\_\_\_\_\_\_\_\_\_ |  No 🞏 |
| Do you have internal stairs? |  Yes 🞏How many? |  No 🞏 |
| Is your home centrally heated? |  Yes 🞏 |  No 🞏 |
| How far are the nearest shops? |  |  |
| How far is the nearest bus stop/train station? |  |  |
| Would you say the area you live in is hilly or flat? |  Hilly 🞏 |  Flat 🞏 |
| Please describe what aspects of your current home make it unsuitable for you, due to impairment/medical condition? |
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| Please tell us why you feel moving home would improve your medical condition/impairment? |
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**MOBILITY PROBLEMS**

Do you have mobility problems which restrict you? Would you say that you are:

Totally Housebound 🞏 Get out occasionally (with assistance) 🞏 No Problems with getting out 🞏

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have difficulty walking? | On the flat 🞏 |  Up or down hill 🞏 |  Distance 🞏 |
| Do you use any of the following? | Walking stick 🞏 | Walking Frame 🞏 |  Wheelchair 🞏 |
| If so how often? | Daily 🞏 | Regularly 🞏 |  Occasionally 🞏 |
| If you have a wheelchair, do you use it indoors or outdoors? | Both 🞏 | Outdoors Only 🞏 |
| Do you require a wheelchair adapted property? |  Yes 🞏 |  No 🞏 |
| Do you have problems with stairs? | Yes 🞏 |  No 🞏 |
| If yes how many stairs do you feel you could manage where there is no lift? | None 🞏 | Up to 3 steps 🞏 |  1 flight 🞏 |
| 2 flights 🞏 | More than 2 flights 🞏 |
| Do you need an extra bedroom due to your impairment or disability? | Yes 🞏 | No 🞏 |
| If yes, why? |

**ADAPTATIONS**

|  |  |  |
| --- | --- | --- |
| Do you require any medical adaptations? |  Yes 🞏 |  No 🞏 |
| If yes, what do you require? |
| Have any of these adaptations been fitted in your current home? |
| If they are not fitted in your current home, why not? Have you made a request to your current landlord to adapt your current property? |

**OTHER HEALTH PROBLEMS**

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| If your health problem is not covered by any of the questions above, please detail how your housing conditions affect your illness? |
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**HEALTH CARE**

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| --- |
| Please give details of your family doctor: |
| Name |  | Address |  |
| Phone No. |  |
| Is there anyone else we could contact for information, e.g. Occupational Therapist, Social Worker? |  Yes 🞏 |  No 🞏 |
| Name |  | Address |  |
| Phone No. |  |
| Please give details if attending hospital regularly: |
| Hospital |  | Reason/Further details |  |
| Consultant |  |
| Phone No. |  |
| Do you receive any of the following welfare benefits due to your medical condition? |
| Disability Living Allowance 🞏 Incapacity Benefit 🞏 Attendance Allowance 🞏  |
| Is this low / high / or middle rate (DLA or AA only)? | Care Component 🞏 Mobility Component 🞏  |

**DECLARATION**

The information detailed on this form will be used to assess your level of medical points as per our Allocations Policy. I declare that the information detailed is accurate to the best of my knowledge. I understand that any false or misleading information could lead to my application being suspended or could have implications for my tenancy if one is granted.

I also give permission for Linthouse Housing Association staff to contact my Doctor, Consultant, Occupational Therapist or Social Worker to verify any of the details on this form if appropriate.

Signed Date

|  |
| --- |
| **OFFICIAL USE ONLY** |
|  | DATE | INITIALS | POINTS |
| Medical self assessment form received: |  |  |  |
| Medical points assessed by: |  |  |  |
| Re-assessed following home visit: |  |  |  |
| Verification requested: |  |  |  |
| Verification received: |  |  |  |
| Re-assessed based on evidence submitted: |  |  |  |
| Maximum medical points confirmed by HCD |  |  |  |
| Notes: |