



Rural Stirling

HOUSING ASSOCIATION

HEALTH & HOUSING NEEDS FORM

NAME:

Confidential

FOR OFFICE USE ONLY:		Application no:	
Date Received:		Grade Awarded:	
Processed By:		Letter Issued:	

**PLEASE READ THESE NOTES BEFORE
COMPLETING THIS FORM**

The key principle of assessing for medical points is that the medical condition itself will not be assessed, but whether a new home can significantly alleviate the condition. We will not normally award medical points if i) your health need or mobility is likely to be temporary (after an accident or operation. ii) your existing home can be adapted and made suitable for your needs

If more than person within the household has a medical condition which means it is necessary to move house, please complete a form for each person. We will only award one set of medical points but this will be to the household member with the most serious need.

Points will be awarded as follows:

Priority A: Extreme	40 points
Priority B: Serious	15 points
Priority C: Significant	10 points
Priority D: None	0 points

Please complete the medical form as thoroughly as possible so that we can assess points as accurately as possible.

We will contact you after your application has been assessed and will tell you how many medical points you have been awarded and how many points in total you have. This will be approximately 2 weeks after you have returned your medical assessment form.

If you have any difficulty reading or writing or are visually impaired or need help in completing the form, please contact us and a member of staff will be pleased to give you advice and assistance.

All applications will be treated confidentially and fairly.

**SECTION 1
INFORMATION ABOUT THE PERSON
WITH THE MEDICAL CONDITION**

Name	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/> (Please select)
Address	
Contact Telephone No	
Date of Birth	
If not Main Housing Applicant, what is your relationship	

SECTION 2
MEDICAL DETAILS

1. What is your medical condition?

2. Please describe how your present house is affecting your health.

3. Is your condition temporary or permanent? Please give details:

4. Do you have any difficulty with walking?

Yes No

If yes, do you use any of the following aids: (please tick appropriate box).

Walking Stick Zimmer Frame

Crutches Wheelchair

5. Have you been assessed by an occupational therapist in your home?

Yes No

If yes, please give details of any recommendations they have made _____

6. Have these been carried out ?

Yes No

If not why not?

7. Have you been provided with any aids to daily living (i.e. handrails, bathing aids) or have any adaptations been carried out to your present home as a result of your health needs?

Yes No

If yes, please tell us why

8. Can you manage stairs?

Yes No

If yes, how many can you manage comfortably?

9. Does the heating in your current home affect your health?

Yes No

If yes, please tell us why

10. Does your condition mean you need an extra bedroom?

Yes No

If yes, please tell us why

11. Please tell us briefly about how your condition affects your daily life in your present home and surroundings (e.g. breathlessness climbing stairs, inability to reach toilet)

12. Please tell us about any impact your condition has on family and carers, and how this could be improved by a change of house

13. Do you have regular contact or help from Social Work services, the NHS or another voluntary agency (e.g. Home Carer, Social Worker, District Nurse, Mental Health Team)

Yes

No

If yes, please tell us what contact, help or services you receive:

SECTION 3
YOUR PRESENT ACCOMMODATION

1. How many bedrooms are there in your current accommodation?

2. What type of house do you live in?

3. What type of heating do you have?

4. Do you have a bathroom/toilet on the same level as your living area?

Yes No

5. Does your bathroom have

A bath: Yes No

A shower over bath: Yes No

A Separate shower unit: Yes No

6. Does your house have internal stairs? Yes No

7. Do you have difficulty with stairs? Yes No

8. Are there handrails on the stairs? Yes No

9. Do you have to climb stairs to get into your house?

Yes No

If yes, please tell us how many stairs there are:

10. Please describe the location of your house (i.e. in hilly area, level site, etc)

SECTION 4
OTHER INFORMATION

1. What is the name and address of your family Doctor (GP)?

Doctor (GP)	
Address	
Contact Number	

2. Is there anyone who is providing you with regular care and support?

Yes No

If yes, please give details:

Name	
Address	
Contact Number	
Please detail the support this person provides you with.	
Relationship to you	

Name	
Address	
Contact Number	
Please detail the support this person provides you with.	
Relationship to you	

3. Do you have an Occupational Therapist, Social Worker or Specialist?

Yes No

If yes, please give details:

Name	
Address	
Contact Number	

4. Is there anything else that you would like to add in support of your application?

SECTION 5 DATA PROTECTION

Declaration

I give permission to Rural Stirling Housing Association to ask my family Doctor (GP), my hospital Doctor/Consultant, and any other agencies with an interest in my health for further information.

I understand that this information will be treated in the strictest confidence and that it will only be used to assess my request for medical priority for re housing.

Signed:	
Date:	

SECTION 6 CONTACT DETAILS

Rural Stirling Housing Association Limited
Stirling Road
Doune
FK16 6AA

Tel: 01786 841101

Fax: 01786 841120

Email: enquiries@rsha.org.uk

Website: www.rsha.org.uk

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<u>Housing Recommendation</u>	
Suitable for wheelchair use	<input type="checkbox"/>
No internal stairs	<input type="checkbox"/>
Gas heating only	<input type="checkbox"/>
Extra bedroom	<input type="checkbox"/>
Level access	<input type="checkbox"/>
Ground floor accommodation only (with maximum of 6 external stairs)	<input type="checkbox"/>
Ground floor and above	<input type="checkbox"/>
Other comments	
<u>Assessment</u>	
Priority A	<input type="checkbox"/> Extreme – 40 points
Priority B	<input type="checkbox"/> Urgent – 15 points
Priority C	<input type="checkbox"/> Significant –10 points
Priority D	<input type="checkbox"/> None – 0 points

Signed: Date:

Authorised by: Date: