Please read the leaflet “Allocation Policy Medical Assessment” before filling in this form.

You should complete this form if you think you or a member of your household’s health or disability is being made worse by your current accommodation.

A disability is a physical or mental illness/impairment, which has substantial and long-term adverse effect on normal day-to-day activities. This is not an assessment of the severity of the medial condition or disability, but an assessment of the need for another home that would ease the medial condition or disability.

You do not need any letter of support from your GP to apply. However, if you already have any information relating to your medical circumstances, you can attach this to your medical assessment form.

If you are unable to complete the form a friend, family member or support worker can complete it for you. If they do they should sign the statement on the back page and explain why they have completed it for you.

|  |
| --- |
| **FOR OFFICE USE ONLY** |
| **Referral Date:** | **Checked by:** |
| **Date Form Received:** | **Housing Reference:**  |
| **Applicant’s Name:**  |
| **Purchase Order Number:** | **Housing Officer:**  |
| **Telephone: 0207 332 3452 / 1237** |  |
| **Respond by email to:**  | **hadvice@cityoflondon.gov.uk** |
| **Other instructions or comments for now medical (documents and reports attached):** |
| **for assessment by:**  | * **general medical adviser**
* **psychiatric adviser**
 |
| **matter to consider:** | * **vulnerability on medical grounds**
* **intentionality**
* **suitability of accommodation**
* **future housing needs**
* **housing application: medical priority**
 |

**Please return this form to:**

**Housing Needs Team, Barbican Estate Office, 3 Lauderdale Place, London, EC1V 8EN**

**Guidance Notes**

**Please ensure you add the following information:**

* What is the applicant’s medical diagnosis or diagnoses?
* Precisely what treatment is he/she on?
* Is there any relevant past medical history?
* Which hospitals, clinics or specialists is he/she under?
* How are his/her daily activities affected by their medical condition?
* Clearly state how your current accommodation affects your medical condition

If you need any help with this form please phone us on: 0207 332 1237 / 3452.

Where it mentions applicant, it means the individual person who needs assessment.

**What you should do:**

• Please complete 1 form for each applicant with a medical condition

• Fill in the medical assessment form in black ink

• Give as much detail as possible.

• Sign and date the form.

• Return the form to us at the address on page 1

**Please try to answer all of the questions.**

We will use the information you give us to assess your household’s housing needs.

We need as much information as possible to make our decision.

**What happens next?**

* If you live in the City of London we may make a referral to an Occupational Therapist to assess whether your home needs adapting to make your life easier. If you live in another Borough we may ask your local social services department for them to do an assessment.
* We may send your form to our independent medical assessors who will consider the information and decide whether any medical points can be awarded.
* We will write to you when a decision has been made.

**All of the information you give us will be treated as strictly confidential. If you give us permission, we may contact the people who you mention in the form who provide you with services or support.** The City of London Corporation is a data controller, and processes personal data in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. For full details of how and why the City of London Corporation processes personal data, please refer to the full privacy notice at [www.cityoflondon.gov.uk/privacy](http://www.cityoflondon.gov.uk/privacy). Alternatively, you can request a hard copy. Please direct all data protection queries to the Information Compliance Team at information.officer@cityoflondon.gov.uk.

|  |
| --- |
| **ABOUT THE PERSON BEING ASSESSED** |
| **Housing application number:**  |  |
| **Name of main applicant:** |  |
| **Date of birth:** |  |
| **Name of person being assessed:** |  |
| **Relationship to the main applicant:** |  |
| **Date of birth:** |  |
| **Address where you currently live:****Postcode:** |  |
| **Contact Phone Number:** |  |
| **Email address:** |  |
| **Correspondence address:** **(if different from above)****Postcode:** |  |

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| **DETAILS OF YOUR CURRENT HOME:** |
| **Please tick the box that applies to your home and fill in appropriate Blanks:** |
| **Type of Home** |
| **Bedsit/Studio Flat** | **🞏** | **Flat** | **🞏** |
| **Maisonette** | **🞏** | **House** | **🞏** |
| **Bungalow** | **🞏** | **Other, please specify below;** | **🞏** |
|  |  |  |  |
| **How many bedrooms are in your home?** |  | **How many bedrooms do you have exclusive use?** |  |
| **If you are in a flat or maisonette, what floor is it on?** |  | **Does your building have a Lift** | **Y🞏/N🞏** |
| **Does your home have heating?** | **Y🞏/N🞏** | **If yes, what type?****…………………………………..** |  |
| **How many bathrooms do you have?** |  | **How many Toilets do you have?** |  |
| **Do you have any of the following?** |
| **Kitchen** | **Y🞏/N🞏** | **Walk in Bath** | **Y🞏/N🞏** |
| **Bath** | **Y🞏/N🞏** | **Bath with an over bath shower** | **Y🞏/N🞏** |
| **Shower** | **Y🞏/N🞏** | **Wet Room** | **Y🞏/N🞏** |
| **If you are lacking any of the above, which do you need?** |
| **TYPE OF TENURE** |
| **Are you a** |  |
| **City of London tenant** | **🞏** | **Tenant in private rented sector** | **🞏** |
| **Tenant in sheltered housing** | **🞏** | **Living in a property you own** | **🞏** |
| **Tenant of another Local Authority** | **🞏** | **member of the armed forces** | **🞏** |
| **Tenant of a Housing Association** | **🞏** | **In a tied or service tenancy** | **🞏** |
| **Staying with parents** | **🞏** | **Rough sleeping** | **🞏** |
| **Staying with relatives or friends** | **🞏** | **Lodger**  | **🞏** |
| **Living in a hostel** | **🞏** | **No fixed abode** | **🞏** |

**Please tell us about your/their ill health or disability and any medication that is being taken or treatment required. (Applies only to those wanting to be re-housed.)**

|  |  |
| --- | --- |
| **Name of Person with medical condition:** |  |
| **Medical condition:**  | **Medication/treatment:** |
| **How does their current home affect their health and why do they want to move?** |

|  |  |
| --- | --- |
| **Are you/they registered blind?** | Y🞏/N🞏 |
| **Are you/they registered disabled?** | Y🞏/N🞏 |
| **Do you/they have an assistance dog?** | Y🞏/N🞏 |

|  |  |
| --- | --- |
| **Does the applicant have difficulty walking?**  | Y🞏/N🞏 |
| **Is the applicant unable to walk?** | Y🞏/N🞏 |
| **Does the applicant have difficulty climbing stairs?** | Y🞏/N🞏 |

|  |  |
| --- | --- |
| **Does the applicant use any of the following?** |  |
| **Walking stick** | Y🞏/N🞏 |
| **Crutches** | Y🞏/N🞏 |
| **Walking frame** | Y🞏/N🞏 |
| **Wheelchair** | Y🞏/N🞏 |
| **Mobility scooter** | Y🞏/N🞏 |
| **Other (please state)** | Y🞏/N🞏 |
| **None of the above** | Y🞏/N🞏 |

|  |  |
| --- | --- |
| **Does the applicant use specialised equipment to manage their illness?** | Y🞏/N🞏 |
| **Is there enough space to store such equipment** | Y🞏/N🞏 |

|  |  |
| --- | --- |
| **Does the applicant get Home Care at the moment?** | Y🞏/N🞏 |
| **If yes, how often do you/they get Home Care? (please tick)** |
| **Less than once a week** | Y🞏/N🞏 |
| **At least once a week** | Y🞏/N🞏 |
| **Most days** | Y🞏/N🞏 |

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| **DOES THE APPLICANT NEED TO BE NEAR SUPPORT SERVICES?** |
| **Hospital**  | **Y🞏/N🞏** | **Doctor/Surgery:** | **Y🞏/N🞏** |
| **Other support services – please give details**  |

|  |  |
| --- | --- |
| **Are your relatives currently giving care or support to you or a member of your household?** | **Y🞏/N🞏** |
| **How often is support needed?** | **What is the nature of this support?** |
| **Relative’s name**  | **Relationship** |
| **Relative’s address:****Postcode** |  |
| **Can we contact this person to discuss your application?** Y🞏/N🞏 |

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| **Do you need an extra bedroom due to the applicant’s medical condition** Y🞏/N🞏 |
| **if yes, please give details** |

|  |  |
| --- | --- |
| **Name of person needing an extra bedroom** |  |
| **Are they currently sharing a bedroom?** | **Y🞏/N🞏** |
| **If yes, with whom?:** |  |

|  |  |
| --- | --- |
| **Is the applicant in receipt of Disability Living Allowance?** |  |
| **Does the applicant have a full-time Carer?** | **Y🞏/N🞏** |
| **If yes please give details and nature of care provided** |  |
| **Does the applicant receive Higher Attendance Allowance:** | **Y🞏/N🞏** |
| **IF YOU ANSWER YES TO EITHER OF THE PREVIOUS QUESTIONS PLEASE PROVIDE A COPY OF DOCUMENTS REGARDING THESE BENEFITS. Copies attached: Y🞏/N🞏** |

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| **You must fill in this section to help us to assess your medical needs.** |
| **Name of doctor:** |  |
| **Address of doctor:****Postcode:** |  |
| **Phone number:** |  |
| **Other (e.g. consultant/specialist, social worker, occupational therapist)** |
| **Name:** |  |
| **Address:****Postcode:** |  |
| **Phone number:** |  |
| **Other (e.g. consultant/specialist, social worker, occupational therapist)** |
| **Name:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Phone number:** |  |
| **Other (e.g. consultant/specialist, social worker, occupational therapist)** |
| **Name:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Phone number:** |  |

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| **Please use this space to tell us any additional information:** |
|  |

**Please make sure that you sign the declaration on Page 8**

**If you do not sign the declaration the form cannot be assessed and will be returned to you. Declaration and authority to seek information**

• I/we confirm that the details I/we have given are to the best of my knowledge true in every respect.

• I/we confirm my/our agreement for you to access medical details from my doctor or specialist in connection with my/our application.

• I/we will notify you of any change in the details provided on the application form.

• I/we authorise you to make any necessary enquiries in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 . This may include sharing your information with other council departments.

• I/we authorise you to make any referrals necessary in connection with my/our application. (This might include referrals to other services such as Occupational Therapy).

• I/we consent to any visits that may be needed to further assess my/our situation.

|  |
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| **signed (applicant):**……………………………………………………………………. Date …………….. |
| **If you have completed this form for the applicant please complete the section below:** |

|  |
| --- |
| **Signed on behalf of applicant:** ……………………………………………………………………. Date ……………..**Name:**…………………………………………………………………….. |
| **Relationship to applicant:** |  |

|  |
| --- |
| **Please tell us why the applicant is unable to fill in the form:** |