

MEDICAL PRIORITY POINTS ASSESSMENT FORM

This Application should only be completed if you or a member of your household have a medical condition which is to be included in your application for housing.

The information contained in this form will be treated in strictest confidence and will only be used to assess entitlement for the award of medical priority points.

This application form can be made available in other languages or in large print on request.

GUIDELINES FOR ASSESSING HEALTH NEEDS AND AWARDING MEDICAL PRIORITY POINT

- 1. Applicants seeking the award of medical priority points will require to complete and submit a Medical Assessment form. The information contained in this form should be sufficient to enable our Housing Management staff to:
 - Assess the level of medical priority points to be awarded
 - Assess the suitability of current accommodation
 - Assess if rehousing would help alleviate/improve the applicant's health problem.

If we require further information to validate an assessment of your medical needs you will be asked to provide further information or obtain a professional opinion from a Consultant, GP etc.

We may also require to carry out a house visit to enable a more detailed assessment of your needs.

Where the health problem relates to stress, depression or other mental health related conditions we will normally require you to provide more specialised information to validate your application in letter from Consultant, Psychiatrist etc.

- **2.** Medical priority points will only be awarded to one member of the household. The household member who has the most health related medical priority will have the points allocated to the application.
- 3. Medical Priority points will be awarded in accordance with the individual category

٠	Priority A	- 100 points
٠	Priority B	- 75 points
•	Priority C	- 25 points

- Priority C 25 points
- **4.** Medical Priority points will not be awarded unless the applicant's current housing conditions is unsuitable for them in terms of their existing medical condition. For example, an applicant with mobility problems, living on the 3rd floor of a tenement property would normally be considered for the award of medical priority points as a move to a ground floor, level access flat would help improve the situation.

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

EXISTING HEALTH PROBLEMS

Do you or any member of your household have any medical /heath problems which you feel are made worse by your current housing accommodation

YES	Γ
NO	[

If you have answered YES, please indicate which member(s) of your household is affected.

NAME		DATE OF BIRTH	
			_
			_
			_
NATURE OF EXISTING HE	ALTH/MEDICA	L PROBLEMS	

IS REGULAR TREATMENT BEING PROVIDED BY A DOCTOR, CONSULTANT OR OTHER HEALTH SPECIALIST. PLEASE TICK (\checkmark)

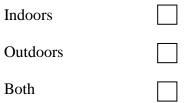
YES	
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HOW IS YOUR CURRENT HOME UNSUITABLE?

HAS YOUR LANDLOF	RD CARRIED	OUT ANY ADAPTATI(ONS Please tick (✓)
YES		NO	
f you have answered yes	please supply v	what type of adaptations ha	ave been done
Shower over bath		Wet floor area	
Level access shower		Stair lift	
nternal handrails		Grab rails	
External handrails		Hoist	
Other (please state)			

YOUR EXISTING ACCOMMODATION

Do you stay in a:						
House Tenement	flat	Cottage fla	at 🗌 Mu	llti storey flat		
If you stay in a flat which floo	or is your fl	at on: _				
How many stairs are there:		-				
If you stay in a house, how m	any interna	l stairs are th	ere:			
If you stay in a house do you	have a bath	room on the	ground floor	YES	NO	
If you stay in a house do you	have a bedr	oom on the	ground floor	YES	NO	
MOBILITY AIDS						
Do you use any of the followi	ing?					
Walking Stick	YES		NO			
Walking Frame	YES		NO			
Wheelchair	YES		NO			
If you use a wheelchair, is it f	or:					



FAMILY DOCTOR

Doctor's Name:					
Address:					
Do you receive su Therapist, Commu			h Professiona	l such as an Occ	upational
YES		NO			
If you have answe	red YES, plea	se provide de	etails		
Name:					
Occupation:					
Address:					
HOSPITAL/CLI	NIC				
Do you regularly a	attend a hospit	tal or clinic?			
YES		NO			
If so, which hospit	al/clinic and h	now often do	you attend		

ADDITIONAL INFORMATION

If you wish to add anything in support of your application for the award of medical priority points, please write in the space below.

DECLARATION

I consent to appropriate enquiry being made in order to verify the information contained in this application.

If further information or confirmation is required, it is the responsibility of the applicant to contact GP/Hospital Consultant to request this.

I also agree to advise the Housing Association about any change in circumstances which may affect this application.

All information contained in this application will be treated confidentially.

Signature of Applicant

Signature of Joint Applicant

Date