Kingsridge Cleddans
HOUSING ASSOCIATION LIMITED

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

- Priority A - 100 points
- Priority B - 75 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 ☐

NO ☐

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

NAME	**DATE OF BIRTH**
_____	_____
_____	_____
_____	_____

NATURE OF EXISTING HEALTH/MEDICAL PROBLEMS

_____

_____

_____

_____

_____

_____

_____

_____

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

YES ☐ **N O** ☐

HOW IS YOUR CURRENT HOME UNSUITABLE?

HAS YOUR LANDLORD CARRIED OUT ANY ADAPTATIONS Please tick (✓)

YES ☐ **NO** ☐

If you have answered yes please supply what type of adaptations have been done

Shower over bath	☐	Wet floor area	☐
Level access shower	☐	Stair lift	☐
Internal handrails	☐	Grab rails	☐
External handrails	☐	Hoist	☐
Other (please state)	☐		

YOUR EXISTING ACCOMMODATION

Do you stay in a:

House ☐ **Tenement flat** ☐ **Cottage flat** ☐ **Multi storey flat** ☐

If you stay in a flat which floor is your flat on: _____

How many stairs are there: _____

If you stay in a house, how many internal stairs are there: _____

If you stay in a house do you have a bathroom on the ground floor **YES** ☐ **NO** ☐

If you stay in a house do you have a bedroom on the ground floor **YES** ☐ **NO** ☐

MOBILITY AIDS

Do you use any of the following?

Walking Stick	**YES**	☐	**NO**	☐
Walking Frame	**YES**	☐	**NO**	☐
Wheelchair	**YES**	☐	**NO**	☐

If you use a wheelchair, is it for:

Indoors ☐

Outdoors ☐

Both ☐

FAMILY DOCTOR

Doctor's Name: _____

Address: _____

Do you receive support from any other Health Professional such as an Occupational Therapist, Community Nurse etc.?

YES ☐ **NO** ☐

If you have answered YES, please provide details

Name: _____

Occupation: _____

Address: _____

HOSPITAL/CLINIC

Do you regularly attend a hospital or clinic?

YES ☐ **NO** ☐

If so, which hospital/clinic and how 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 _____