

Ref no. _____

Confidential

Self Assessment Medical Form

This self-assessment application form is used to assess the following

- **Section 2** **How does your housing affect your illness – (medical points)**
- **Section 3** **If you require a specially adapted property**
- **Section 4** **If you need an extra bedroom for a carer or due to an illness or disability**

Policy Decisions

Points will be awarded to an applicant suffering from anxiety or depression only if he/she is receiving medical treatment on a regular basis.

Points will not be awarded to applicants who have a disability or disabling illness which affects their mobility where they will not consider ground floor or first floor accommodation.

Applications for an additional bedroom will be decided individually by merit, and must be supported with information provided by a health professional.

Please complete Section 1 and any other section which relates to your housing application.

Section 1

Name of main applicant	
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Please give details of the person for whom medical points are being sought

Name	
Address	

Describe in your own words what health problem or disability you have

What medical treatment and/or medication are you receiving?

Section 2 How does your housing affect your illness – (medical points)

Does the design or the condition of your house affect your illness?
 (for example, you may have poor mobility and you live in an upper tenement flat or your home suffers from dampness)

Yes		No	
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If yes please give details

Would re-housing alleviate your medical condition? If so, is re-housing essential or advisable? Please give reasons

- essential would be your health would be greatly improved, for example you live on a top floor tenement and have severe mobility issues
- advisable may be that there is a link between your housing and poor health

Please give reasons why you think re-housing is either essential or advisable

Section 3 If you require a specially adapted property

Do you use a walking aid?	Yes		No	
Do you use a wheelchair?	Yes		No	
	If yes, do you use it indoors or outdoors?	Both	Outdoors only	
Is your current home wheelchair adapted?	Yes		No	
Would you use a wheelchair inside your home if the property was suitable?	Yes		No	
Do you have difficulty getting in and out of the bath?	Yes		No	
Do you have difficulty getting on and off the toilet?	Yes		No	
Can you manage stairs inside your home?	Yes		Need help	No
Can you manage stairs to the entrance to your home?	Yes		Need help	No

Section 3 (continued)

Do you reach any of the following rooms by using internal stairs?

Bedroom	Yes		No	
Bathroom	Yes		No	
Only Toilet	Yes		No	

Have there been any adaptations made to your home?	Yes		No	
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Do you need further adaptations to your home?	Yes		No	
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If yes, please provide details

If you have any further difficulties with mobility in your home that are not listed above, please provide details

Section 4 If you need an extra bedroom for a carer or due to an illness or disability

Do you need an additional bedroom due to illness or to accommodate a 'non residential' carer, if so please provide details.

Section 4 (continued)

If you, the applicant do not receive pension credits please provide the following information

Are you, your partner, or a member of your family in receipt of disability living allowance care component at the middle or high rate?	Yes		No	
Is a member of your household in receipt of attendance allowance?	Yes		No	

If no, can you provide a letter from one of the following agencies confirming why you need an extra bedroom due to illness or to accommodate a non residential carer

- your doctor
- the Social Work Department
- NHS health professional, health visitor or occupational therapist
- respite care organisation/ private care organisation.

This information may also be required If you are in receipt of housing benefit and are likely to be affected by the 'bedroom tax'.

Please give us the name and address of your GP and that of any other health care professional with whom you have had recent contact.

GP/ Health Professional	Name	
	Address	
	Telephone Number	

Do we have permission to contact any of the above people if we need more information about your health?	Yes		No	
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Signature _____ **Date** _____