WELWYN HATFIELD

HNR Reference Number	
ID Number (office use only)	

MEDICAL INFORMATION FORM

HOUSING REGISTER APPLICANTS

If you need any help with this form please contact the Housing Advice Team on 01707 357613

Guidance Notes

You should complete this form if you or a permanent member of your household are seeking medical priority for rehousing because:

- You have a diagnosed recognised physical or mental health condition which is permanent or long term. This will not usually include pregnancy related illness.

AND

- You can demonstrate that your present housing is having a long term adverse affect on your health and that this adverse affect can only be improved by rehousing.
- We do not normally assess medical priority on grounds of pregnancy, relationship, marriage, neighbour problems or other emotional problems or defects in the condition of your home

What you should do:

Complete the medical information form giving as much detail as possible.

YOU MUST COMPLETE ALL SECTIONS OF THE FORM IN FULL UNLESS OTHERWISE STATED

- Complete and sign the medical consent section.
- Provide copies of relevant information, such as prescription, proof of Disability Living Allowance.
- Return the form to the Housing Needs Department.

It is not necessary to get your GP or Consultant to complete the form or write to us. If you have a supporting letter from a medical professional or support worker involved in your care you may submit a copy with this form, however it is not essential.

In line with our procedures, all medical forms will be initially assessed by the Housing Advisor, who will make a final decision on whether to submit to our Independent Medical Advisor for full assessment. If your form is not submitted, reasons will be provided in writing.

You should supply the full contact details of all professionals involved in your treatment.

WELWYN HATFIELD

Section 1 : Your Personal Details

Title (Mr/Mrs/Miss/Mx)	
Name	
Address	
Post code	
Daytime telephone number	

Details of person with illness or disability

Full name	
Date of birth	
Relationship to you	

Please tell us about all the people who live permanently with you

Full name	Relationship to you	Date of birth

Section 2 : Your Current Accommodation

House ☐ Maisonette ☐

Flat ☐ Bedsit ☐

Bungalow ☐ Mobile Home ☐

Caravan ☐ Other (please state) .....

If you live in a flat, maisonette or bedsit, which floor is it on?

Ground ☐ First ☐

Second ☐ Third ☐

Other (please tell us) ☐

Is there a lift?

☐ Yes

☐ No

How many bedrooms are there in your home? ☐

Do you or any of the people included on your application share a bedroom?

☐ Yes

☐ No

If 'YES', who with?

☐

How many steps are there to your front door? ☐

How many steps or stairs are there inside your home? ☐

Is your central heating Gas ☐ Electric ☐ Other ☐ None ☐

How is your heat provided? Radiators ☐ Storage Heaters ☐ Gas Fire ☐ N/A ☐

Is your bathroom Upstairs ☐ Downstairs ☐ Both ☐

Is your toilet Upstairs ☐ Downstairs ☐ Both ☐

Section 2 : Your Current Accommodation (cont)

Do you receive help or support from any of the following? (Please tick boxes as applicable)

Social Services	☐ Yes	☐ No
Home Carer	☐ Yes	☐ No
Community Psychiatric Nurse	☐ Yes	☐ No
Mental Health Team	☐ Yes	☐ No
Learning Disabilities Team	☐ Yes	☐ No
Occupational Therapist	☐ Yes	☐ No
District Nurse	☐ Yes	☐ No
Heath Visitor	☐ Yes	☐ No

Other (please state)

Section 3 : Medical Condition

Please state the nature of your current medical condition

Section 3 : Medical Condition (cont)

If you are currently receiving treatment or medication please give details below. Please give proof of this such as your prescription or a label from the container that we can photocopy (this should be your most recent medication and not more than three months old) or appointment letters.

Name of treatment/ medication	Amount taken/dose	How often	When started

Are you in receipt of disability living allowance or personal independent payment?

Yes ☐ No ☐

If 'YES', are you in receipt of the care or mobility component and at what rate eg, low, medium or high? Please provide proof of this.

Section 4 : Mental Health Issues

This section is to be completed ONLY by applicants seeking medical priority on the grounds of mental health issues. Other applicants please go straight to Section 5.

Please describe you mental health issues:

Do any of the following reflect your situation? (Please tick boxes as applicable).

Difficulty remembering things	☐ Yes	☐ No
Risk of harming yourself	☐ Yes	☐ No
Difficulty caring for yourself	☐ Yes	☐ No
Difficulty caring for others	☐ Yes	☐ No
Difficulty getting on with others	☐ Yes	☐ No

Section 4 : Mental Health Issues (cont)

Have you ever been referred to a psychiatrist because of your mental health issues?

☐ Yes

☐ No

If 'YES', please tell us their name, the address and telephone number of the hospital or clinic and when you last saw them:

Name:	
Address:	
Telephone Number:	
Date last seen:	

If you have ever been admitted to hospital because of your mental health issues, when were you last in hospital and for how long?

Section 5 : Mobility Difficulties

Do you have difficulties climbing stairs? ☐ Yes ☐ No

If 'YES', how many flights of stairs can you climb?

☐ None ☐ One ☐ Two ☐ Three ☐ More than three

Do you have mobility difficulties which require you to use a walking aid, for example, do you use a walking frame or stick?

☐ Yes

☐ No

Do you use a wheelchair?

☐ Yes

☐ No

Section 5 : Mobility Difficulties (cont)

If 'YES', please confirm whether you use a wheelchair in your home, to get about outdoors or both.

If you have other housing needs linked to difficulties with walking please give full details

Can you manage a bath?

☐ Yes

☐ No

Section 6 : Adaptations

Do you need adaptations in your home?

☐ Yes

☐ No

If 'YES', please complete the rest of this Section. If 'NO', please go straight to Section 7.

What adaptations do you have in your current home?

Section 6 : Adaptations (cont)

What adaptations do you need?

Has your current home been assessed for possible adaptations?

- Yes
- No

If 'YES', please confirm when the assessment took place, who completed the assessment and the outcome of the assessment. **Please provide us with a copy of the assessment.**

Section 7 : Support Contacts

Please give details of all the medical professionals and support workers involved in treating any conditions described in this form, ie GPs Occupational Therapists, Social Workers, Community Psychiatric Nurses, Consultants and Specialists.

Service 1

Medical Condition	
Name of Service	
Name of Person Seen	
Address	
Telephone Number	

Service 2

Medical Condition	
Name of Service	
Name of Person Seen	
Address	
Telephone Number	

Service 3

Medical Condition	
Name of Service	
Name of Person Seen	
Address	
Telephone Number	

Service 4

Medical Condition	
Name of Service	
Name of Person Seen	
Address	
Telephone Number	

Section 8 : Your Housing Needs (please answer all questions)

How long have you been affected by your illness or disability that you have described?

Please describe fully how your illness or disability affects your housing needs:

Please describe fully how your present home is making your illness or disability worse:

What type and size accommodation do you think you need and why:

Section 9 : Declaration and Consent

By submitting this form I agree that I will notify the Welwyn Hatfield Borough Council of any changes in my circumstances that affect the details I have given on the form.

I certify that the information I have given on this form is true and correct to the best of my knowledge. I understand that knowingly making false statements could give the council grounds for cancelling or amending my housing application or for prosecuting me. I also understand that I could lose any tenancy granted as a result of my giving false information.

I give permission for council staff to contact other agencies for information relevant to assessing my housing and medical need and for those agencies to supply information to the council.

I understand that you can store any information I have given on this form on your computer and this may be seen by any Local Authority Housing Association or Agency that offers homes to people on the Housing Needs Register.

This Authority is under a duty to protect the public funds it administers and to this end may use the information you have provided on this form for the prevention and detection of fraud. It may also share this information with other bodies responsible for audition or administering public funds for these purposes.

For further information see the council's website (Data Protection Statement) or contact the Data Protection Officer or Audit Manager at your local Council Office.

Signed:		Date:	

Print name:	

FOR USE BY WHBC STAFF ONLY:

Housing Advisor or Neighbourhood Housing Officer's comments:

Signed: .....

Dated: ..... Housing Officer: .....

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