**Kingsridge Cleddans HA Application Medical Form**

* Medical points are awarded only when a move can alleviate medical needs. Not all medical needs may be impacted by a change in housing.
* Whilst priority will be allocated to people with medical needs, specific needs, this will also limit the availability of suitable housing.
* Please provide the details of the household member with the medical needs impacted by a move. If more than one member is impacted, please provide the details of the member who is most impacted.
* The duty lies on applicants to provide as much information as possible and to provide evidence of this. Medical professionals will not normally release information to the Housing Association. We are not trained medical professionals and cannot make assumptions about your medical needs. Please include any supporting evidence you may have with this application. This should include supporting letters from medical practitioners.

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| Applicants Name |  |
| Address |  |
| Phone number |  |
| Name of person with medical condition, if different |  |
| Relation to applicant |  |

**Section 2: Medical Details**

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| 1. What is their medical condition(s)? |
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| 1. Please describe how the present property is affecting their health. |
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| 1. Is the medical condition temporary or permanent, and are their needs likely to change with time? |
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| 1. Do they have any difficulty walking? |
| Yes No  If yes, do they use any of the following aids (Please tick all that apply)  Walking stick Crutches Zimmer Frame  Wheelchair (external)    Wheelchair (internal) |
| 4a. Can they safely manage stairs? |
| Yes No  If yes, how many can they manage safely? |

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| 5. Have any adaptations been carried out to the present home? |
| YesNo  If yes, please give details: |

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| 6. Is there a requirement for an extra bedroom for a live-in carer? |
| YesNo  If yes, please give details: |

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| 7. Is there anyone within our area that provides you with care or support? | |
| YesNo | |
| Name |  |
| Address |  |
| Contact Number |  |
| Please detail the support this  person provides you with |  |

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| 8. Other details that support your application |
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| **Declaration**  I hereby confirm that the above information is correct and accurate.  I understand that this information will be treated in the strictest confidence and that it  will only be used to assess my request for medical priority for rehousing. | |
| Signed: |  |
| Date: |  |

**Please remember to include any supporting evidence.**