

MEDICAL APPLICATION

We will not contact your doctor for medical information. Supporting information will need to be provided by yourself. Many doctor's charge for this service, Blaby District Council is unable to pay these charges which will remain payable by yourself.

All questions relate to the person with the medical condition, who must be part of the household. You will need to demonstrate how the medical condition would be improved by a move to a different home.

Where we require evidence this will be shown and a complete list for you to tick is in Part 13

If you wish to add any further information please attach it to this form

IF YOU HAVE A VISUAL IMPAIRMENT PLEASE REQUEST THIS FORM IN A LARGER PRINT OR MAKE AN APPOINTMENT FOR ASSISTANCE

Part 1 Personal Details

Title (Mr, Mrs, Ms etc)	<input style="width: 95%;" type="text"/>	Date Of Birth	<input style="width: 15%; text-align: center; font-size: small;"/> Day <input style="width: 15%; text-align: center; font-size: small;"/> Month <input style="width: 15%; text-align: center; font-size: small;"/> Year <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/>
Surname	<input style="width: 95%;" type="text"/>	Gender	<input style="width: 20px; height: 20px;" type="checkbox"/> Male <input style="width: 20px; height: 20px;" type="checkbox"/> Female
First Name(s)	<input style="width: 95%;" type="text"/>		
National Insurance No	<input style="width: 15%; text-align: center; font-size: small;"/> Letters <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> Numbers <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> Letter <input style="width: 15%; text-align: center; font-size: small;"/>		
Flat Number	<input style="width: 95%;" type="text"/>	County	<input style="width: 95%;" type="text"/>
House Number	<input style="width: 95%;" type="text"/>	Postcode	<input style="width: 95%;" type="text"/>
Street	<input style="width: 95%;" type="text"/>	Home Phone	<input style="width: 95%;" type="text"/>
Town or Village	<input style="width: 95%;" type="text"/>	Other Phone	<input style="width: 95%;" type="text"/>
E-mail	<input style="width: 95%;" type="text"/>		

Part 2 People living with you

Please tell us about everyone who is living with you, not including yourself

	Person 1	Person 2	Person 3
Surname	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
First Name(s)	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Date Of Birth	<input style="width: 15%; text-align: center; font-size: small;"/> Day <input style="width: 15%; text-align: center; font-size: small;"/> Month <input style="width: 15%; text-align: center; font-size: small;"/> Year <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/>	<input style="width: 15%; text-align: center; font-size: small;"/> Day <input style="width: 15%; text-align: center; font-size: small;"/> Month <input style="width: 15%; text-align: center; font-size: small;"/> Year <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/>	<input style="width: 15%; text-align: center; font-size: small;"/> Day <input style="width: 15%; text-align: center; font-size: small;"/> Month <input style="width: 15%; text-align: center; font-size: small;"/> Year <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/> <input style="width: 15%; text-align: center; font-size: small;"/>
Gender	<input style="width: 20px; height: 20px;" type="checkbox"/> Male <input style="width: 20px; height: 20px;" type="checkbox"/> Female	<input style="width: 20px; height: 20px;" type="checkbox"/> Male <input style="width: 20px; height: 20px;" type="checkbox"/> Female	<input style="width: 20px; height: 20px;" type="checkbox"/> Male <input style="width: 20px; height: 20px;" type="checkbox"/> Female
Relationship to you	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Which bedroom do they use 1,2,3,4 or 5	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>

Person 4**Person 5****Person 6**

Surname

First Name(s)

Date Of Birth

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Gender

 Male Female

 Male Female

 Male Female

Relationship to you

Which bedroom do they use 1,2,3,4 or 5

Part 3 Present Property

Number of living rooms

Number of bedrooms

Which of the following describes where you live?

Owner Occupier

A Lodger

Living in a Hostel

Council Tenant

Living with Relatives

Private Tenant

Other

Have you contacted social services about your accommodation?

 Yes No**Part 3a****Flats**

Do you live in a flat or Maisonette?

 Yes No

Go to part 3b

 Yes No

Go to part 3b

Which Floor do you live on ?

Does it have a lift ?

 Yes No Yes No

Go to Part 4

Go to Part 4

Part 3b**Type of property you live in or you stay the most?**

House

Maisonette

Bungalow

Sheltered Accommodation

Other

Part 4 Health Problems

Please describe your medical condition

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Please list your prescribed medication

Name of medication	Dosage e.g. 5mg	How many times taken per day

Evidence needed see the checklist at Part 13

Regular Support

If you receive regular support from anyone please provide their occupation e.g. district nurse, occupational therapist, community psychiatric nurse, social worker, home care or carer, and their contact details.

Name		
Occupation		
Flat Number		
House Number		
Street		
Town or Village		
County		
Postcode		
Phone Number		

Evidence needed see the checklist at Part 13

Do you regularly attend a hospital and/or clinic

Yes

No

Go to part 4a

If the answer to the above is YES, please provide their names and addresses evidence needed see checklist at part

...

Name of Doctor

Hospital/Clinic

Street

Town or Village

County

Postcode

Phone Number

What is your daily alcohol consumption?

Do you smoke cigarettes/pipe/tobacco

Yes

No

Do you receive any benefits or DLA due to your ill health and/or disability

Yes

No

Go to part 5

Please state what benefits you receive

Please state what level of care and mobility you receive and if there are any mental disorder or impairment.

Care Level

Mobility Level

Mental disorder or impairment

Evidence needed see the checklist at Part 13

Part 5 Moving about your Current Accommodation

Do you have difficulty in moving around your current accommodation

Yes

No

Go to part 6

Do you have difficulty walking?

Yes

No

Please tick any of the following that you use

Walking Stick

Walking Frame

Wheel Chair

Other

Where do you have to use your wheelchair?

Indoors

Outdoors

Both

Do you have difficulty climbing steps inside or outside your home

Yes

No

What type of access do you have to your property?

Shared Ramped Level Other

Number of steps to your property

Number of steps you can manage easily

Has your property been assessed/adapted for any adaptations, which may assist you to manage the stairs or steps i.e. a grab rail, bathing aids, stair lifts etc Yes No

If YES, please indicate what type of equipment

If NO, are you prepared to have the property assessed by an Occupational Therapist Yes No

Part 6 Bathroom

Which of the following does your bathroom have (Please tick)

Bath Shower over bath Separate shower unit Level access shower

Do you have difficulty using the bath, shower or toilet Yes No

If YES, please tell us what problems

Do you have to go upstairs to the bathroom Yes No

Do you have to go upstairs to the toilet Yes No

Part 7 Heating

What sort of heating do you have?

What sort of heating would you prefer?

Please describe how your heating or lack of heating affects your medical condition.

Some of our sheltered housing schemes have communal storage heating. Is this suitable? Yes No

If No please explain why

Part 8 Bedroom

Do you have to go upstairs to the bedroom?

Yes

No

Does your illness or disability mean you need an extra room?

Yes

No

If YES, please tell us why you need this, e.g. for a carer or for medical equipment (what type of equipment) evidence required please see part ...

If you have difficulty sleeping with your partner please explain why you cannot share the same bedroom with twin beds, and over what period of time this has been.

Part 9 Damp

Do you consider that your property is damp

Yes

No

If so give reasons and advise us if you have contacted your landlord to resolve this issue. Evidence required see checklist at part...

Part 10 Location

Is your property on a steep hill?

Yes

No

What distance can you manage to walk up the hill

Do you require close distance for car parking to a property

Yes

No

If so what distance can be easily managed

Part 11 Shops and Transport

Do you have problems getting to the shops

Yes

No

What is the approximate distance from the shops and amenities

How do you get to the shops

Walk Bus Car Taxi

Does the disabled person drive?

Yes

No

If the disabled person is transported by car how frequently would this occur.

Part 12 Living Independently

Does the disabled person need access to, and use of the kitchen

To make drinks To make snacks To prepare meals

Does the disabled person operate heating, lighting power switches Yes No

Do these need to be at wheelchair height? Yes No

Does the disabled person carry out domestic duties for themselves? Yes No

If No Please explain who carry's out the following tasks and the frequency that assistance is provided

Food Preparation

Caring for children

If the disabled person is a wheelchair user please provide the following information:

Height of wheelchair

Are leg raises used as a permanent fixture Yes No

What is the total length of wheelchair when leg raiser is used.

Is the wheelchair electric or manual

Electric or Manual

Does anyone else assist with wheelchair use?

Do you have any mental disorders, impairment or learning difficulties Yes No

Are you provided with support for any of the above difficulties? Yes No

Do you have a CPN (psychiatric Nurse or key worker) Yes No

PLEASE TELL US HOW YOUR MEDICAL CONDITION COULD BE IMPROVED BY A MOVE TO ALTERNATIVE ACCOMMODATION

Part 13 Checklist

Please tick next to each type of evidence you are sending with this application. We must see original documents, not copies.

If the documents are valuable please bring them to the Main Council offices in Narborough, the Joint Service Shop in Blaby or the Civic Centre in Braunstone Town, where we can copy them and give them straight back to you.

You application will not be considered until we have all the evidence needed.

The following document required from all medical applicants

Evidence from your Doctor or Specialist confirming your medical condition e.g. letter

Where relevant for each applicant please provide the following documents

Repeat prescription

Occupational Therapist report

Evidence of Support from any professional body, key worker, CPN etc.

Evidence of any contact with Landlord to resolve issues affecting medical health.

Part 14 Applicants Declaration

I Understand

The information I have given on this form is complete and accurate, and if I have provided false information, Blaby District Council may take action against me, and this may include legal action to repossess any Tenancy that I have been granted.

I agree to advise Blaby District Council of any changes in my medical condition which may affect this application.

I/we authorise Blaby District Council to make any investigations that are required to deal with my/our application for housing.

I agree to a home visit by the Council's Housing officer if requested.

All information given in this form is to my knowledge correct as at today's date.

Signed

Date

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Data Protection Statement

The information on this form will be used by Blaby District Council to assess your housing needs. The information will be held by Blaby District Council's Housing Division in accordance with the terms of the Data Protection Act 1998.

Any information you provide may be checked with other agencies or bodies in order to:

1. Verify the details of your application
2. Manage your current or future housing needs.

For further details on the information we may hold about you please write to:

Information Management Officer, Council Offices, Desford Road, Narborough, Leicestershire LE19 2EP