Barrhead Housing Association Limited

1986-2016: Celebrating 30 years working in the community

Medical Priority Application Form

MEDICAL SELF ASSESSMENT

TO BE COMPLETED IF (OR ANYONE MOVING WITH YOU) SUFFERS FROM ANY ILLNESS OR DISABILITY WHICH IS ADVERSELY AFFECTED BY YOUR PRESENT ACCOMMODATION.

NAME OF PERSON

_____

Medical Conditions

Please list all medical conditions, the medication you take and describe how your current accommodation affects each condition. (If you can please provide a copy of your repeat prescription)

_____

_____

_____

Medical Condition (s)	Medication	How Would Moving Home Improve this condition?

Getting Around in Your Home

Do you have difficulty walking?	✓
Yes	
No	

If yes are any of the following used	✓
Walking Stick	
Walking Frame	
Wheelchair	

If you use a wheelchair, do you use it?	✓
Indoors only	
Outdoors only	
Both	

Is there a lift in your building?

Yes ☐ No ☐

Stairs

Do you have difficulty climbing stairs?	✓
Yes	
No	

Do you have to go upstairs to the following?	✓
Toilet	
Bathroom	
Bedroom	

How many stairs are there in your property?	
Inside	
Outside	

How many stairs can you manage overall?	
Inside	
Outside	

Bathroom

Does your bathroom have?	✓
Shower over bath	
Separate shower unit	
Wet Floor Shower	
Bath only	

Do you have difficulty using any of the following?	✓
Bath	
Shower	
Toilet	

Which facilities would best suit your medical needs? Please select only ONE option	✓
Bath only	
Shower over bath	
Separate shower unit	
Wet Floor Shower	

Barrhead Tenants Only

In some cases, Barrhead Housing Association may be able to adapt your home to make it more suitable for your needs allowing you to remain in your current accommodation. In this case, we would refer your application to an Occupational therapist.

Do you wish to consider this option?

YES ☐ **NO** ☐

Other Health Problems

If your health problem is not covered by any of the above questions, please describe how your current accommodation affects your health or disability, and why a move would benefit your health

Doctor/Hospital

Please provide details of your family doctor and any consultants you see on a regular basis.

Doctor's Name:	
Surgery Address:	
Tel No:	

Consultant's Name:	
Department:	
Hospital:	

Other Support

If you get support from anyone else, such as homecare services or assistance with personal care functions, district nurse, psychiatric nurse or occupational therapist, please provide their names and addresses.

Name:	
Occupation:	
Address:	
Tel No:	

Name:	
Occupation:	
Address:	
Tel No:	

DECLARATION

PLEASE READ CAREFULLY THE DECLARATION BELOW AND THEN SIGN THE FORM AND RETURN IT TO OUR OFFICE

I/We certify that the information which I/we have given in this application form is correct and complete, and I/we consent to Barrhead Housing Association making such enquiries as may be necessary to confirm the information I/we have given.

Should I/we be offered rehousing by Barrhead Housing Association, I/we consent to the disclosure of this fact to other public sector landlords, in accordance with the terms of the Data Protection Act.

I/we understand that any false or misleading information, or information deliberately with-held, may result in the cancellation of my application or in Barrhead Housing Association seeking repossession of any tenancy that may be granted to me/us.

I/we undertake to give immediate notification of any changes in my/our circumstances.

Signature of Applicant: _____

Date: _____

Signature of Joint Applicant: _____

Date: _____

For official use only

Confirmation of Information following Home Visit/Office Interview

Signature of Applicant: _____

Signature of Joint Applicant: _____

Date: _____

Signature of Visiting/ Interviewing Officer: _____

Date: _____