Please return completed Application Form to:

Housing Office
Civic Centre, PO Box 28
Beecroft Road
Cannock
Staffordshire
WS11 1BG

Tel: 01543 462621
Fax: 01543 464534

How we use your personal information

The information provided will be used by Cannock Chase Council, who are the data controller. We will only share your information when necessary, with other departments such as Housing benefits, Council Tax, Environmental Health and external agencies such as Social Services, Staffordshire Police, NHS Choices, or where the law requires or allows us to. For further information please see: **www.cannockchasedc.gov.uk/PrivacyNotice**

This leaflet can be provided in Braille, on audio cassette tape/disk, **large print** on request to **Cannock Chase Council** on **01543 462621**.

? = **01543 462621**

Email:customerservices@cannockchasedc.gov.uk

Updated June 2018

Cannock Chase COUNCIL

Medical Need Assessment

for Housing Applicants

Cannock Chase Housing

www.cannockchasedc.gov.uk

Medical Need Assessment

The Council's Medical Assessment Panel is made up of Senior Medical practitioners and Housing Officers and Support Group representatives. They will assess the medical circumstances of the application and determine the effect re-housing would have on the applicants. The Medical Assessment Panel will award using the Assessment Matrix on page 10 and will give one of the following awards:-

- **High Priority**
- **Medium Priority**
- **Low Priority**
- **No Priority**

This form should be completed if you think your home affects your medical condition.

The information provided on this form will be used by the Council's Medical Panel. It is important that you provide as much information as possible to allow a full assessment to be made of your case, including any supporting documentation.

If you have difficulty in completing the form, please contact the Allocations Team who can give you advice. Any incomplete forms will be returned.

The Medical Panel will make one of the following decisions

- Extra information is required to enable an assessment to be made.
- The priority awarded will be either High, Medium, Low or None.

You will be notified of the Medical Panels decision in writing.

Should you disagree with the panel's decision, you can request a review giving your reasons in writing and provide supporting evidence.

APPLICANTS SHOULD NOT APPROACH THEIR DOCTOR TO COMPLETE THIS FORM

Notes:

For office use only

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For office use only

Housing Services
Medical Need Assessment

1

Name and address of applicant	Tel. No.	Application No.

2

Name of person with medical condition	Date of Birth	Occupation

2.1

Current Accommodation (Please tick)					
Council Tenant	H/A Tenant	Private Tenant	Lodger	Owner Occupier	No fixed abode

2.2

Type of Property Currently Occupying (Please tick)					
House	Flat	Bungalow	Bedsit	Maisonette	Other

2.3

Bedrooms (Please tick)					Heating		
1	2	3	4	5	Gas	Electric	Solid Fuel

2.4

Does your current accommodation have any adaptations? Yes ☐ No ☐ (If yes, please tick which below)					
Hand rail	Wet room	Stairlift	Ramp	Pendant alarm	Other

3

Mobility Restrictions							
Can you walk independently? (please tick)				**Are you confined to a wheelchair?** (please tick)			
Yes		**No**		**Yes**		**No**	
If no, which of the following aids do you use?				**Do you require assistance in accessing upstairs?**			
Wheelchair	**Frame**	**Sticks**	**Other**	**Yes**		**No**	

4

What financial help do you receive? Proofs of benefits to be attached				
Personal Independence Payment			**Attendance Allowance**	
Care Component Rate				
Low	**Middle**	**High**	**Low**	**High**
Mobility Component Rate				
Low			**High**	

5

Medical Conditions Proofs to be attached including doctors statement		
Medical Condition	**Prescribed medication**	**How long**

REVIEW OF MEDICAL DECISION

Registration No: .....

Applicant Name: .....

Applicant Address: .....

Original Decision: .....

Medical Panel Comments:

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Date: .....

Signature: .....

DECLARATION

To the best of my knowledge the information I have entered on this form is true. I give permission for the above information to be placed before the Council's Medical Panel.

I am aware that to give false information knowingly or recklessly may result in the Council cancelling my application or recovering possession of any tenancy that is granted to me and that in certain circumstances I may be liable to prosecution. (Housing Act 1985).

Signed ..... Date.....

Signed ..... Date.....

Note: In joint applications both parties must sign above

To be completed by Medical Panel only

	None	Low Band 3	Medium Band 2	High Band 1
Physical Health				
Mental illness/ learning disability				
Environment				

Ground floor required Yes / No

Level access required Yes / No

Wet room required Yes / No

Comments of Medical Panel

Medical Conditions Continued... Proofs to be attached including doctors statement		
Medical Condition	**Prescribed medication**	**How long**

5.1

How are your medical conditions affected by your current accommodation? Supporting evidence to be provided

5.2

What type of property do you wish to move to?

5.3

Do you need a level access shower or any other adaptation? OT report to be attached

5.3

Would this new property improve your health/medical condition? If so, how?

6

Help from others If you have a care company please give company name address and telephone number	
Do you have regular help from others with daily activities?	
Yes:	**No:**
If yes, please give details	

6.1

Support from Organisations	
Name: **Agency:**	**Name:** **Agency:**
Name: **Agency:**	**Name:** **Agency:**

7

Any other relevant information