Application for Re-Housing - Medical Priority

You have indicated that you require re-housing due to a medical condition that you or someone who lives with you has. Please complete this application in support of your request. You should provide as much information as possible to help us to make a decision as quickly as possible. The completion of this form does not guarantee that a Medical Priority will be awarded.

Tenant/Householder Name .....

Person Applying for Medical Priority .....

Address ..... **Contact No** ***Home*** _____

Mobile .....

Please list ALL members of your household

please delete as appropriate

Name	Date Of Birth	Relationship	Moving With Applicant
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO

When did you move to your present address? .....

What type of property do you live in? *Please* ✓ *As appropriate*

Tenement ☐ **Multi Storey** ☐ **Maisonette** ☐ **4-in-a-block** ☐

Bungalow ☐ **Terraced** ☐ **Semi Detached** ☐ **Other** ☐

Which floor do you live on? ☐ *e.g., ground, 1st, 2nd etc*

How many steps are there to your front door? ☐

If you have internal stairs, please tell us how many. ☐

How many bedrooms are there in your home? ☐

What type of heating do you have? ***Gas*** ☐ ***Electric*** ☐ ***Solid Fuel*** ☐ ***Other*** ☐

Is the property centrally heated? ***Yes*** ☐ ***No*** ☐

Application for Re-Housing - Medical Priority

Do you have a garden? ***Yes*** ☐ ***No*** ☐

Do you have shops within easy reach? ***Yes*** ☐ ***No*** ☐

Do you have your own transport? ***Yes*** ☐ ***No*** ☐

Would you say the area you live in is hilly or flat? ***Hilly*** ☐ ***Flat*** ☐

Please list your medical conditions and how long you have had them:

Name of your condition	How long have you had it?

..

Please state how your medical conditions affect you with day to day activities e.g. housework.
Please provide as much information as you can.

Application for Re-Housing - Medical Priority

List all medication you are **currently** receiving (please copy name from the bottle or packaging)

Name of your Medicine	How often do you take it?

Application for Re-Housing - Medical Priority

How long (**in minutes**) can you walk for on flat ground before you need to stop?

If you have a walking difficulty, please tell us why you need to stop? *e.g. breathlessness*

How many steps can you climb?

If you have any difficulty with stairs, please tell us why.

Why do you feel your present house unsuitable?

Application for Re-Housing - Medical Priority

What type of housing would overcome the problems you have with your current housing?

Do you require housing all on the one level? ***Yes*** ☐ ***No*** ☐

If 'Yes', please tell us why

Do you require sheltered accommodation? ***Yes*** ☐ ***No*** ☐

If 'Yes', please tell us why

Are you in receipt of Disability Living Allowance or Attendance Allowance? If so, please tell us which rate you receive.

Mobility Component	Tick	Care Component	Tick
Low Rate		**Low Rate**	
High Rate		**Middle Rate**	
		High Rate	

Application for Re-Housing - Medical Priority

Have you ever applied for Disability Living Allowance or Attendance Allowance? If so, please tell us when:

.....

Are you registered blind? ***Yes*** ☐ ***No*** ☐

Do you use any of the following?

Wheelchair ☐ ***Zimmer*** ☐ ***Tripod*** ☐ ***Walking Stick*** ☐

If you use one of the above, who provided your Mobility Aid? e.g. self purchased, physiotherapist etc

.....

Do you use the aid (Please tick as appropriate)

	Always	**Regularly**	**Occasionally**
Inside your home			
Outside your home			

Have any adaptations been carried out to your present accommodation because of your medical needs? ***Yes*** ☐ ***No*** ☐

If 'Yes', please specify what these are

Is your present house fitted with a Housing Alarm ***Yes*** ☐ ***No*** ☐

Have you been admitted to hospital in the past 12 months? ***Yes*** ☐ ***No*** ☐

Application for Re-Housing - Medical Priority

Date of Admission _____ **Length of Stay** _____

Hospital _____

Reason _____

Please give us the name and address of your GP

.....

.....

Please give us the name and address of any hospital specialist you attend

.....

.....

Have you applied for medical priority before? ***Yes*** ☐ ***No*** ☐

If **'YES'** when did you apply?.....

Do you have family support? ***Yes*** ☐ ***No*** ☐

If **YES**, please give us their details

.....

.....

State relationship .....

Details of support given .....

.....

Application for Re-Housing - Medical Priority

Please use this space to provide us with any more information you feel is relevant about your housing needs

DECLARATION

"Cadder Housing Association is registered under the Data Protection Act 1998. Glasgow Housing Association is under an obligation to properly manage public funds. Accordingly information that you have provided on this form may be used to prevent and detect fraud and may also be shared for the same purpose with public bodies or other organisations which handle public funds."

CONSENT

- **I agree to this information being passed to Cadder HA's medical and disability advisers for the purposes of assessing my application**.
- **I give consent for the medical advisers to give guidance to Cadder HA about my medical conditions, level of function and any other information that may be needed to assess my application.**
- **I accept that there is no right of appeal.**

Application for Re-Housing - Medical Priority

Signed (applicant) ..... **Date** .....

Please return the Application to your local housing office : _____

Application for Re-Housing - Medical Priority

OFFICE USE ONLY

Application Reference | **Date Received**

Decision (tick)

Medical A Ground flat level housing	Medical A No restrictions	Medical B	Denied	Referred to Medical Advisors

Date of Decision

Further Information if required

Housing Officer Name _____ **Housing Officer Signature** _____