

Tonbridge & Malling Borough Council

Medical and welfare assessment form

Call 01732 876067
Email housing.services@tmbc.gov.uk
Visit www.tmbc.gov.uk



Guidance notes for the completion of the medical and welfare assessment form

Please complete the form with as much detail as possible if:

- you have a housing need and want us to take your medical condition or welfare and support needs into consideration; or
- you have applied as a homeless person and want us to assess your vulnerability on the grounds of physical or mental illness or disability. Consideration will be given to the legal test of vulnerability i.e. whether, when homeless, you are less able to fend for yourself, so that you would suffer injury or detriment in circumstances where a less vulnerable person would be able to cope without harmful effects; or
- you feel your current accommodation affects your (or a family member's) disability or ill-health; or
- you are already included on our housing register and have had a change in your circumstances (e.g. medical condition worsened, new medical condition for yourself or family member); or
- you need to move closer to family members to give or receive emotional or practical support; or
- you are at risk of severe emotional or physical trauma resulting from violence (including racial or homophobic attacks and domestic violence) or threats of violence, or physical, emotional or sexual abuse.

Please note: you are not required to obtain a medical certificate or letter from your doctor. If necessary, we will contact your doctor directly. To do this, we require you to sign the declaration within the medical and welfare assessment form, giving your consent. However, if you already have a medical certificate, letter or report in your possession, please enclose with this form. If more than one person in your household has a medical condition or welfare/support need, each person will need to complete a separate form.

Medical priority is not usually awarded for the following conditions:

- stress and depression due to environmental factors such as overcrowding or relationship breakdown, unless symptoms are very severe and evidence is provided by a NHS consultant psychiatrist (not a non-medically qualified psychotherapist); or
- pregnancy; or
- temporary/short term illness or injury; or
- fear of lifts or unwarranted concerns over lift reliability; or
- consideration of distance to hospitals/other agencies or carers within the Tonbridge & Malling area; or
- drug and / or alcohol dependency where there is no evidence of current active engagement with the appropriate support services.

Details of both your medical condition/welfare needs and current accommodation will be considered along with any recommendation of the housing medical/welfare panel before a decision is made on the level of priority on medical or welfare grounds. Please complete each part of the form as fully as possible, sign the declaration at the end and then send it to us, together with any relevant original documents to:

Housing Services, Tonbridge & Malling Borough Council, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ.

If you need assistance completing the form or require an assessment form in another format please contact us on 01732 876067.

1. Personal details

Details of person to be assessed:

Surname: First name(s):

male female date of birth:

Occupation:

How do you travel to school / work?

Current address:

.....

.....Post code:

Tel. no: home work / mobile:

If **not** main applicant, relationship to main applicant

Main applicants full name: reference number:.....

2. Details of physical/mental illness/condition, or disability:

.....

.....

How long have you had this condition?

Please list all the medication you are taking at the moment (e.g. tablets, medicine, creams, inhalers). Please include the strength and how often you need to take your medication, and when you first started to take it. If **none**, please state this is the case.

Name of medication	Dosage	How often taken	Taken since

At the moment, are you receiving medical treatment from your GP/hospital consultant/physiotherapist or other health professional? **yes** **no**

If **yes**, please give details:

.....

.....

.....

.....

Are you awaiting further investigation / hospital referral / surgery for your illness / disability / medical condition? **yes** **no**

If **yes**, please give details:

.....
.....
.....

3. Details of current housing

What type of property do you live in? (*please circle*)

B+B/hotel house flat-ground floor
maisonette hostel/night shelter flat-above ground floor

Other (please specify):

How many bedrooms do you have?

What floor is the entrance to your home?

Are there any stairs **within** your home? **yes** **no** **If yes**, how many?

Is there a lift(s)? **yes** **no** **If yes**, does it go to your floor? **yes** **no**

If **no**, how many stairs are there from the lift to your flat: _____ steps

Please state below **how many** steps there are from street level to the main entrance to your house, flat or maisonette: _____ steps

If there is no lift **how many** steps are there from the main entrance to your front door? _____ steps

Do you have central heating? **yes** **no**

If **no**, please explain what form of heating you have:

.....

Do you have use of your own kitchen and bathroom? **yes** **no**

If **no** please state where these are located:

.....

If you think that your current accommodation is having a significant detrimental affect on you or members of your household, please explain below:

.....
.....
.....
.....

4. Mobility details

If you can walk independently (without using a walking stick or walking frame) and have no other mobility problems **please go on to section 5: Further information.**

Do you use a: walking stick / walking frame / wheelchair / other (*please specify*)?:

.....

Do you have difficulty climbing **one** flight of stairs (e.g. 14 steps)? **yes** **no**

Do you have difficulty climbing one or two steps? **yes** **no**

Do you use a wheelchair? **yes** **no**

If yes, do you use this inside your accommodation? **yes** **no**

Are you registered disabled or blind? **yes** **no**

If yes, please state registration number:

Do you require adaptations to your home due to your disability? **yes** **no**

If yes, please give details:

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.....

.....

Have your needs been assessed by an occupational therapist? **yes** **no**

If yes, please give details:

.....

.....

Are you unable to work / only capable of part-time work, or have had to change

occupation because of a medical condition or disability? **yes** **no**

If yes, please give details:

.....

.....

Are you in receipt of: *please circle*

statutory sick pay / incapacity benefit / disability living allowance (mobility component/care component) / income support / job seekers allowance / state pension?

5. Further information

Can you carry out the following tasks unaided?

use a bath **yes** **no** use a WC **yes** **no**

wash (self) **yes** **no** wash (clothing) **yes** **no**

shopping **yes** **no** cooking **yes** **no**

cleaning/housework **yes** **no** drive/use public transport **yes** **no**

If you have answered **no** to any of these, please give details of what help is needed:

.....
.....

How does your illness / disability affect you in your day to day/social life?

.....
.....
.....

Do you drink alcohol? **yes** **no**

No of units per week: *please circle* Under 5 5-10 11-20 21-30 31-40 40+

Do you use drugs / solvents? **yes** **no**

Do you use: *please circle* cannabis / heroin / cocaine / amphetamines / other?.....

Have you ever undertaken a detox? **yes** **no** Date:

If you need to move closer to family members to give or receive emotional or practical support please state:

Support needs.....

Given to/received from

Relationship to you

Where do they live

.....
.....

Is there any other information you would like to be considered?

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.....
.....
.....
.....
.....
.....

6. Details of your doctor, hospital consultant, district nurse, health professional or support worker

Please complete part 1 in **all** cases, and any others that apply:

1. Name of your GP / family doctor:	
Surgery address	
Telephone number	
Date of last visit	

2. Name of your hospital consultant:	
Hospital department	
Hospital address	
Date of last visit	

3. Name of (<i>please circle</i>) your district nurse, community psychiatric nurse, physiotherapist or other health professional:	
Full address	
Telephone number	
Date of last visit	
How often do you see them	

4. Name of (<i>please circle</i>) social worker, probation officer, community mental health team or community drug project support worker:	
Full address	
Telephone number	

5. Name of any other agency support worker or carer:	
Full address	
Telephone number	

7. Declaration

Before you return this form, please sign the declaration below. In all cases, the household member with the health or welfare problem or disability must sign the declaration. If this person is aged under 18 years, then their parent or legal guardian should sign in their place.

I confirm that the information provided on this form is true, and that I will inform Tonbridge & Malling Borough Council if there are any changes in my medical condition or housing needs. I give my permission for my doctor / hospital consultant / other health professional / support worker to give details about my health and support needs, related to my application for rehousing, to Tonbridge & Malling Borough Council's housing medical/welfare panel.

(Please note that we will not always consult your doctor).

Full name: DOB:

Signature:date:

Parent / Guardian of: DOB:

Data protection statement

This Council is under a duty to protect the public funds it administers and to this end may use the information you have provided on this form for the prevention and detection of fraud. It may also share this information with other bodies responsible for auditing or administering public funds for these purposes.