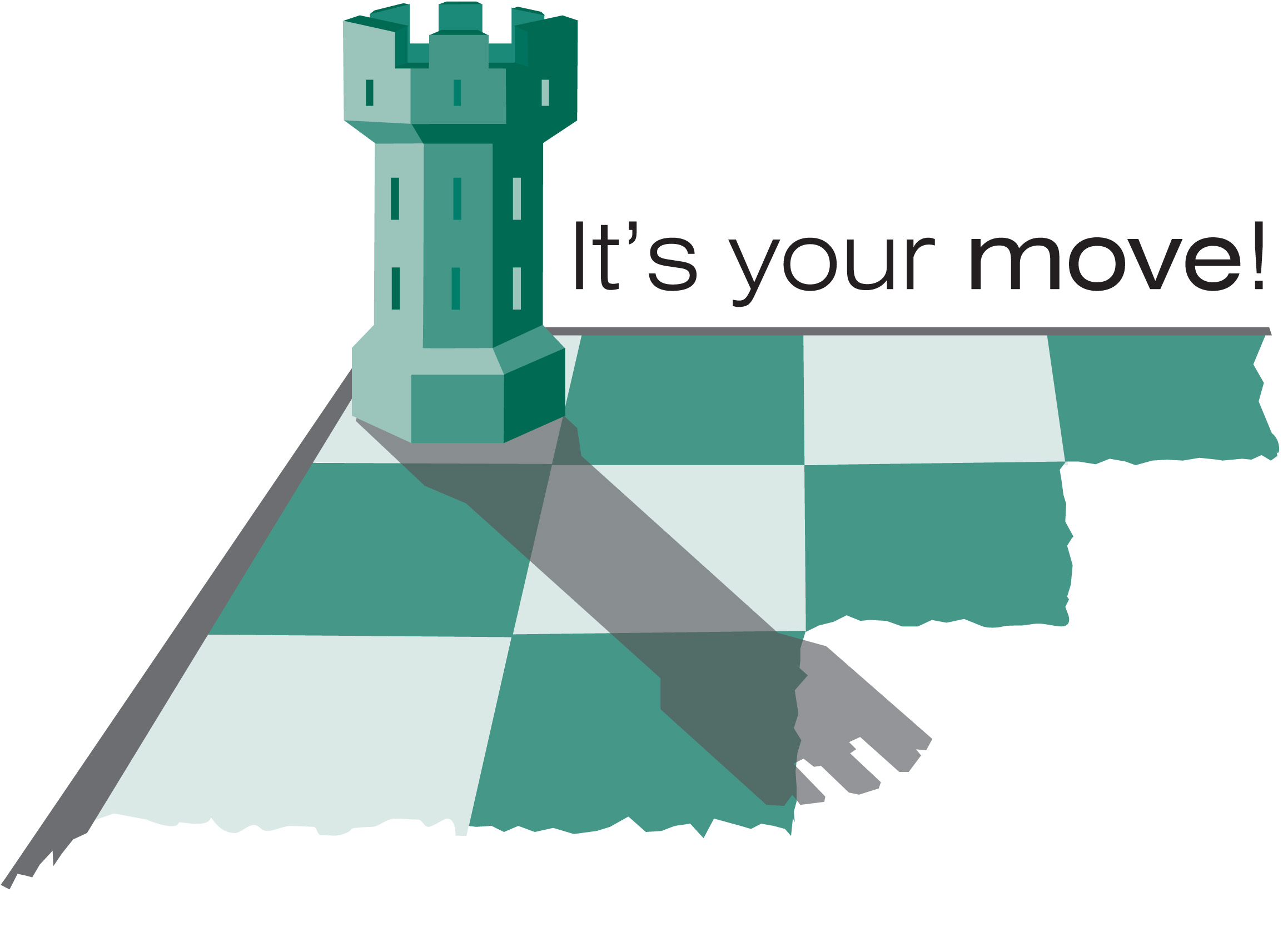
Warwick District Council

**Medical Assessment Form (MAF1)**

Customer Self-Assessment – HOME CHOICE



**This form should only be completed by customers who need to move home if a disability/medical condition is made significantly worse by their current accommodation.** We will take into account the information you provide in order to: make an assessment of your housing needs and vulnerabilities and assess your HomeChoice banding. If you have any difficulties completing this form – please speak to a member of the Housing Advice Team.

|  |
| --- |
| **PART ONE: About you and your household** |

|  |
| --- |
| **Name of main applicant:** |
| **Address:** |
|  |
|  |
| **Telephone No:**  **Personal Email address:** |

|  |
| --- |
| **Date of birth:** |

|  |
| --- |
| **Please give details of everyone who currently lives with you and or usually lives with you but is currently living at a separate address:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship to You | Age | Address (if different to above address) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Please give us details about the household member with medical needs – please complete a self- assessment form (MAF1) for each person in your household who has medical needs.** |

|  |
| --- |
| **Name** |
| Date of birth: |
| Relationship to main applicant: |

|  |
| --- |
| **Please give a brief description of disability/medical condition/diagnosis:** |
|  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **How often does this person need to see a Doctor or attend hospital appointments for their medical condition? (Please tick)** | | | | | | | |
| **Weekly** |  | **Monthly** |  | **Every 3 – 6 Months** |  | **Occasionally** |  |

|  |  |
| --- | --- |
| **Please state type of current prescribed medication and dosage:** | |
| **Details of medication** | **Length of time on medication** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Name of Doctor:** |
| **Address:** |
|  |
| **Telephone No:** |

|  |
| --- |
| **Name of Hospital Doctor/Consultant/Health Professional:** |
|  |
| **Address:** |
|  |
| **Telephone No:** |

|  |
| --- |
| **Employment or Welfare Benefits:** |
| **Please give details of current job and hours worked** |
|  |
| **Please give details of any Welfare Benefits received by the person with the medical need or on behalf of this person?** |
|  |
|  |
|  |

|  |
| --- |
| **Please provide copies of any relevant supporting documentation from health or social care professionals if available and any award notices of DWP disability benefits such as Attendance Allowance, Carers Allowance, Disability Living Allowance or Personal Independence Payment.** |

|  |
| --- |
| **Does the person with medical needs have a diagnosed mental illness including a Personality Disorder – if so, please give details below:** |
|  |

|  |
| --- |
| **In the last 12 months – has the person with medical needs been admitted to hospital because of their medical condition including for example a visit to accident and emergency or psychiatric in-patient assessment?** |
|  |

|  |
| --- |
| **Is the person with medical needs due to have any planned operations/surgery in the next 12 months? If so – please give details below including name of hospital** |
|  |

|  |
| --- |
| **Is the person with medical needs Registered Disabled? (hearing impaired, blind, partially sighted) – If yes please give details below** |
|  |

|  |
| --- |
| **Does the person with medical needs have a serious learning disability such as ADHD, Autism, Asperger’s or significant learning impairment** |
|  |

|  |
| --- |
| **PART TWO: About your current accommodation** |

|  |  |
| --- | --- |
| **Existing accommodation *(tick one only) Total* Bedrooms ( )** | |
| Bungalow | Flat/Maisonette above ground floor |
| House | Lift |
| Ground Floor Flat/Maisonette | Other (Please Specify) |
| Sheltered Accommodation |  |

|  |
| --- |
| **Does your existing accommodation have any aids and adaptations?** |
| Access Ramp  Level access shower or wet room  Low-level units  Grab rails  Stair lift |
| **Has your home been specially adapted as a result of an Occupational Therapy (OT) assessment?** |
| YES  NO |

|  |  |  |
| --- | --- | --- |
| **How many stairs?** | **a)** Within your home ( **)** | **b)** to access your home **( )** |

|  |  |  |
| --- | --- | --- |
| **Are you housebound?** | Yes  No | |
| **Do you use any of the following aids?** | **a)**  a walking stick or frame | **b)** a wheelchair or mobility scooter |
|  | **c)**  other, please specify: | |

|  |
| --- |
| **Do you have any of the following support in your current home?** |

|  |  |
| --- | --- |
| **Community Alarm, Telecare, Care line** | (Tick) |
| **Warden Alarm – Resident Warden on site** | (Tick) |
| **Personal Care package: Social Care Assessment** (daily, weekly, monthly visits) | (Tick) |

|  |
| --- |
| **Please tell us about how your medical issues are made worse by your accommodation for example I cannot walk upstairs, I cannot get in and out of the bath.** |

|  |
| --- |
| **Do you need an additional room for a live-in carer or do you need to sleep in a separate room from your partner because of a medical condition that stops you from sharing a room?** **Please give details in the space below.** |

|  |
| --- |
| **PART THREE: SIGNED AUTHORISATION AND CONSENT** |

**Your Declaration.**

I confirm that the details in the attached Medical Assessment form are true. I understand that any false or misleading statement or withholding any relevant information, now or in the future, may result in my application being cancelled or any tenancy granted to me ending, or may lead to a prosecution for criminal offences. I understand that it is an offence under Section 171 of Part 6 of The Housing Act 1996 to give false statements, withhold information or fail to disclose a change of circumstances in relation to any application processed by Warwick District Council. A person guilty of an offence under this section is liable on conviction to a fine of up to £5,000.

**Why do we collect this information?**

We need the personal information you supply so that we can check if you are eligible to be housed through HomeChoice on medical grounds. HomeChoice is a partnership between Warwick District Council and Registered Providers (Housing Associations) who work together for the purpose of prioritising the allocation of social housing. The legal basis for processing your information is under the Councils public duties as set out in part 6 and part 7 of the Housing Act 1996, as amended.

**What information is collected?**

* Name
* Address
* Household details
* Financial circumstances
* Employment details
* Housing circumstances
* Health details

**Who has access to the information?**

The information you provide will be accessible by Local Authority staff working in the Housing Advice and Allocations Teams. It is shared with other social housing landlords so they can allocate their properties appropriately. The information may also be shared with other organisations for example; other Local Authority departments, medical practitioners and advisers, Government Departments and Agencies.

**How long is the information kept?**

The information will be kept electronically for six years after the date of our last contact with you.

Further details on your statutory rights, and other privacy information can be found on our website at: - <https://www.warwickdc.gov.uk/privacy>

**I authorise Warwick District Council Housing Advice and Allocations Team to make enquiries regarding my medical conditions in order to decide if medical banding applies in relation to my application for housing through HomeChoice. I give consent for Warwick District Council to share any information or data relating to this HomeChoice application including medical information to the third parties mentioned below and authorise those third parties to provide information (including sensitive information) to Warwick District Council for the purposes of assisting me with housing. I understand that the following authorisation (consent) is being given for myself and on behalf of any members of my household who are aged under 16.**

**Confirmation of third parties**

1. NHS Trusts, Hospital Doctors and GP
2. Recovery Partnership (CGL)
3. Support and Social Workers
4. Health Visitors

Applicant Full Name: (Print)…………………………………………

Signature …………………………………………………………….

Date …………………………

Full Name: (Print)……………………………………………………

*(of the household member with a medical need)*

Signature …………………………………………………………….

*(of the household member with a medical need)*

Date ………………………….

Full Name: (Print)……………………………………………………

*(of the household member with a medical need)*

Signature …………………………………………………………….

*(of the household member with a medical need)*

Date ………………………….