

# MEDICAL PRIORITY APPLICATION FORM



## IMPORTANT INFORMATION: PLEASE READ PRIOR TO COMPLETION

### Who can apply for medical priority?

If you have a physical, sensory or mental health condition that means you cannot manage in your home and are unable to resolve your situation you can apply for medical priority by completing this form. **Please complete an additional form for any other household members who wish to apply for medical priority, i.e. a couple in which both have medical needs.**

### How do we establish if you have a medical need?

The Occupational Therapist Support Officer and/or the Occupational Therapist will consider the information you have provided in this form and supporting information. **If you do NOT provide the supporting information we may be unable to make an assessment of your needs.** The assessment may include us visiting you in your home or contacting your GP/ Consultant/ Psychiatrist.

### What information MUST I provide?

**Please complete ALL sections of the Medical Priority Application Form and supply following:**

- Patient Summary from your GP Surgery or copy of your most recent prescription.
- If you claim - A copy of your most recent award letter for any benefits that you claim for your ill health and/or disability. (eg. Personal Independence Payment or Attendance Allowance).
- If you attend – A copy of current hospital or clinic appointment letters.
- Owner Occupiers – A copy of your most recent mortgage statement and confirmation of any outstanding loans or debts secured against your property, IVA or bankruptcy details.

### I own my own home can I complete a Medical Priority Application Form?

Owners can complete a Medical Priority Application but we will also carry out a financial assessment. This is to establish if you can resolve your own circumstances, for example by selling your current home and buying another.

### The value of my home or my income exceeds £120,000, can I complete a Medical Priority Application Form?

You can complete a Medical Priority Application but we will carry out a financial assessment also to establish if you can resolve your own circumstances.

### How will this affect my application?

If you qualify for a priority, we will award it from the date the assessment is completed. If your application is active you can still place bids whilst the assessment is being carried out.

### What should I do if my circumstances change?

You **MUST** let the Doncaster HomeChoice team know who will reassess your application and decide whether this will affect your priority.

### What can I do if I am unhappy with the decision you have made?

You can request a review of our decision within 28 days of the decision letter that we send. For more information see our booklet 'A Guide to Doncaster Council's Allocation Policy'.

### How do I apply for Extra Care?

Extra Care is supported accommodation for older applicants with a range of identified care needs and can include rented or shared ownership, we are able to refer you to DMBC if this is your preferred option or you can contact DMBC's Adult Contact Team on 01302 737391 for further info.

## About You

Title (Mr/Mrs/Miss/Ms)	
First Name	
Last Name	
Date of Birth	
Full Address	
Post Code	
Phone number/s	
<b>Housing Application number</b>	

## Medical Diagnosis/Health Problems

Please tick the below boxes which apply to you. What is the nature of your illness/disability?

Physical  Mental Health  Sensory

Please list your diagnosed medical conditions below **(If you have sent us a patient summary from your GP Surgery, there is no need to complete this box):**

Do you receive input from a healthcare professional? No  Yes  (provide details below)

Has a formal diagnosis been given by a healthcare professional? No  Yes

### You may be asked to provide medical evidence for any reported conditions/illness

Who is your GP?

Name		Practice	
------	--	----------	--

Who is your Consultant?

Name		Hospital	
------	--	----------	--

What is your Height and Weight?

Height		Weight	
--------	--	--------	--

Have you had a recent fall?

Yes		No	
-----	--	----	--

If yes, please provide further details and dates:

Have you had a recent hospital admission (within 12 months)?

Yes		No	
-----	--	----	--

If yes, please provide further details and dates:

Your Mobility	Indoors	Outdoors
Walking stick/crutches		
Walking frame		
Attendant push wheelchair		
Self-propelled wheelchair		
Powered wheelchair (not scooter)		
Mobility Scooter		

Personal Care	Yes	No	Describe your difficulties
Can you dress/undress yourself?			
Can you manage personal hygiene?			
Can you manage toilet hygiene?			
Can you feed yourself?			
Do you need help taking medication?			

Transport	Yes	No
Are you able to drive?		
Can you get in/out of a car?		
Do you have a blue badge?		
Do you use public transport?		
Do you go to see your GP?		

### About Your Home (please tick the box which best applies)

Who owns your home?

Owner occupied		Housing Association	
St Leger Homes		Private Landlord	

What is your weekly household income?

Up to £200 <input type="checkbox"/>	£200 to £300 <input type="checkbox"/>	£300 to £400 <input type="checkbox"/>	£500+ <input type="checkbox"/>
-------------------------------------	---------------------------------------	---------------------------------------	--------------------------------

If you have ticked owner occupied, please complete the following section:

What is the estimated value of your property?	
Do you have an outstanding mortgage? <b>Please provide details and a copy of your mortgage statement</b>	
Do you have an interest only mortgage?	
Do you have any loans or debts? <b>Please provide details and a copy of your loan/debt statement</b>	

Please describe your home

House		Bungalow	
Ground floor flat		Flat; first floor and above <b>Lift? Yes/No</b>	
Caravan/Mobile home		Other (please describe)	
Number of bedrooms		Number of reception rooms	

Accessing your home	Yes	No	Describe your difficulties
Can you get in/out of your home?			
Can you open the door to let people in?			
Can you get in/out of your kitchen?			
Can you get in/out of a living/sitting room?			
Can you access a bedroom to sleep?			
Can you access a toilet?			
Can you get in/out of your bathing facilities?			
Can you get up/down your stairs? (if applicable)			

Does anyone provide you with help/support?

Yes		No	
-----	--	----	--

Is the care they provide: Formal  Informal Care

If yes, please provide details of who and what help/support they give:

Do any of these people have Power of Attorney, appointee or deputyship?

If yes, please provide details:

Are you a current or former member of the Armed Forces?

Yes		No	
-----	--	----	--

If so, between which dates did you/ have you served?

### Adaptations And Equipment

**Equipment:** - Commonly provided to help people to be more independent, for example, a bath board, perching stool, raised toilet seat, shower chair or a device to make furniture higher.

**Adaptations:** - An adaptation is an alternation or addition to your home to help you live as independently as possible, for example, grab rails, stair lift, stair rails, ramps, level-access showers and over-bath showers.

Is there any equipment or adaptations in your home? Yes  (give details below) No

Would you consider further adaptations to your home? Yes  No   
For example- Level access shower, stairlift, ramp, grab rails

### About Your Request For Services

Do you feel you are at risk of injury or harm? Yes  (give details below) No   
In your own words please describe why this is.

Please tell us about your current difficulties in as much detail as possible.

How do you think we can help you?

## Data Protection Statement/Consent Agreement/Declaration

### **Data Protection Statement**

St Leger Homes and Doncaster Council has a duty to protect public funds and we may use the information you have provided for the prevention and detection of crime. We may also share information with other council departments or external organisations in order to undertake our functions as a Local Authority. We will comply with the requirements under the Data Protection Act 1998 and never give information about you to anyone else or for another purpose unless the law allows us.

It may be necessary for us to contact your GP/other professional to clarify information that you have provided.

### **Consent**

Do you consent to us contacting your GP or other Health Care professional?

Yes

No

Do you consent to us sharing your information where/when necessary?

Yes

No

### **Declaration**

I have provided the details requested in this form and declare that this is a true representation of my personal circumstances and that the facts given are true to the best of my knowledge. I consent to it being held on file under the terms of the Data Protection Act 1998.

Applicants full name:

\_\_\_\_\_

Applicants signature:

\_\_\_\_\_

Date:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

FOR OFFICE USE ONLY

Evaluation/outcomes: