TOWER HAMLETS

tower hamlets homeseekers

BGVPHA Bethnal Green & Victoria Park HA

east end HOMES

LABO

Old Ford HA

Provident Row HA

Poplar HARCA

Southern Housing Group

Spitalfields HA

SWAN

Tower Hamlets Community Housing

ToynbeeIslandHomes

Application for Rehousing on Health Grounds

This includes both physical & mental ill health

PLEASE READ 'APPLYING FOR A HEALTH PRIORITY' LEAFLET BEFORE COMPLETING THIS FORM

OFFICE USE ONLY	Housing reference number								

Please DO NOT ask for a letter from your GP or hospital doctor. If a medical report is needed it will be requested.

1 About you

Mr/Mrs/Miss/ Ms/etc.	First name	Last name

Address	How can we contact you?
Full postcode	Tel. *home* Tel. *work* Tel. *mobile*
Occupation	E-mail address

If you are known by another name or are staying at another address, please tell us what it is and confirm a telephone number where we can contact you.

If you are a single person, who is your next of kin? Please tell us their name, relationship, address and telephone number.

Are you filling in this form for someone else? No ☐ Yes ☐

If *No* go to Section 3, if *Yes*, what is your name?	
Relationship to applicant	
Your address	
Your telephone number	

Does the applicant know you are filling in this form? No ☐ Yes ☐

2 About your household

Please list all the people living at your address, **including yourself**. Please tick a box for those who have a health problem and for those who wish to be rehoused together.

First name	Surname	Date of birth	M/F	Relationship	Health problem?	Housed together?
		DD-MM-YY				
		DD-MM-YY				
		DD-MM-YY				
		DD-MM-YY				
		DD-MM-YY				
		DD-MM-YY				
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		DD-MM-YY				
		DD-MM-YY				

3a Your health - *part 1*

Please describe the problems - physical and mental - and/or disability of those people listed in Section 3.
MORE SPACE AVAILABLE IN SECTION 10 IF NEEDED

Full name of person with health problem

When did problem begin?

What is the health problem?

Full name of person with health problem

When did problem begin?

What is the health problem?

Full name of person with health problem

When did problem begin?

What is the health problem?

Full name of person with health problem

When did problem begin?

What is the health problem?

3b Your health - *part 2*

What practical difficulties do each of those people listed in Section 3 experience in their current home
MORE SPACE AVAILABLE IN SECTION 10 IF NEEDED

Full name of person with health problem

How does your home restrict the person with the health problem?

Full name of person with health problem

How does your home restrict the person with the health problem?

contd....

3a Your health - *part 2 continued*

Full name of person with health problem

How does your home restrict the person with the health problem?

Full name of person with health problem

How does your home restrict the person with the health problem?

4 About your present home

Name of your landlord

How many bedrooms does your home have?

How many people share your home with you?

What floor level is your front door on?

Is your home a:

flat maisonette house bungalow ?

Do you have a garden? No Yes

Does your property have a lift? No Yes If *Yes*, how many lifts are there in the block?

How many steps are there to your front door?

If you have internal stairs in your home, how many do you have?

Are your bathroom & toilet combined? No Yes

If you live in a house or maisonette, is your toilet: upstairs downstairs ?

Does your home have any adaptations? No Yes If *Yes*, please let us know what they are:

grab rails stair-lift through floor lift ceiling track hoist bathing equipment

other adaption *please describe*

5 About the type of home you want

In your opinion, what type of home do you need?

Do you need extra space for your health care? No Yes

If *Yes* please give details - *e.g. wheelchair access, storage for medical equipment, etc.*

What FLOOR LEVEL would you be prepared to live on? With lift Without lift

6 About your doctor and other health professionals

Full name of person with health problem	Name and address of doctor
	Tel ☎
Full name of person with health problem	Name and address of doctor
	Tel ☎
Full name of person with health problem	Name and address of doctor
	Tel ☎
Full name of person with health problem	Name and address of doctor
	Tel ☎

Is there any other health or social service staff involved in providing care? No Yes
(e.g. occupational therapist/district nurse/physiotherapist/social worker)

Full name of person with health problem	Name and address of health professional/social worker
	Tel ☎
Full name of person with health problem	Name and address of health professional/social worker
	Tel ☎
Full name of person with health problem	Name and address of health professional/social worker
	Tel ☎
Full name of person with health problem	Name and address of health professional/social worker
	Tel ☎

7 Treatment of the person with a health problem (person 1)

Full name of person with health problem	Name of consultant and address of hospital where treatment is taking place

Hospital record number (if known)

Date of next appointment

Please detail any treatment and list all medicines and tablets you are taking, including ointments, sprays, creams, inhalers, etc.

Treatment	Name of Medication and Dose (e.g. 250 mg)	How often do you take the medicine?

7 Treatment of the person with a health problem (person 2)

Full name of person with health problem	Name of consultant and address of hospital where treatment is taking place

Hospital record number (if known)

Date of next appointment

Please detail any treatment and list all medicines and tablets you are taking, including ointments, sprays, creams, inhalers, etc.

Treatment	Name of Medication and Dose (e.g. 250 mg)	How often do you take the medicine?

7 Treatment of the person with a health problem (person 3)

Full name of person with health problem	Name of consultant and address of hospital where treatment is taking place

Hospital record number (if known)

Date of next appointment

Please detail any treatment and list all medicines and tablets you are taking, including ointments, sprays, creams, inhalers, etc.

Treatment	Name of Medication and Dose (e.g. 250 mg)	How often do you take the medicine?

7 Treatment of the person with a health problem (person 4)

Full name of person with health problem	Name of consultant and address of hospital where treatment is taking place

Hospital record number (if known)

Date of next appointment

Please detail any treatment and list all medicines and tablets you are taking, including ointments, sprays, creams, inhalers, etc.

Treatment	Name of Medication and Dose (e.g. 250 mg)	How often do you take the medicine?

8 Walking, getting about, care and support (person 1)

Full name of person with health problem

Is walking difficult? No Yes If YES, in what way?

How far can you walk on level ground? *Please tick appropriate box*

Indoors only | 10 yards/metres | 200 yards/metres

1/4 mile/400 metres | 1/2 mile/800 metres | Over a mile/over 1500 metres

When moving about, is any of the following used? *Please tick appropriate box*

Wheelchair | Walking frame | Crutches | With assistance of another | None

If you do, are these used indoors? No Yes

How many stairs can you climb? *Please tick appropriate box*

None | 1-3 steps | 8-12 steps | 2 flights | 3 flights

Do you need equipment to go up or down? No Yes

Have you ever fallen when standing or walking? No Yes

Do you leave home alone? *Disregard if the person is young child* No Yes

If support care is provided, how often does this happen? *Please tick appropriate box*

Daily | Weekly | Fortnightly

How is this help needed?

8 Walking, getting about, care and support (person 2)

Full name of person with health problem

Is walking difficult? No Yes If YES, in what way?

How far can you walk on level ground? *Please tick appropriate box*

Indoors only | 10 yards/metres | 200 yards/metres

1/4 mile/400 metres | 1/2 mile/800 metres | Over a mile/over 1500 metres

When moving about, is any of the following used? *Please tick appropriate box*

Wheelchair | Walking frame | Crutches | With assistance of another | None

If you do, are these used indoors? No Yes

How many stairs can you climb? *Please tick appropriate box*

None | 1-3 steps | 8-12 steps | 2 flights | 3 flights

Do you need equipment to go up or down? No Yes

Have you ever fallen when standing or walking? No Yes

Do you leave home alone? *Disregard if the person is young child* No Yes

If support care is provided, how often does this happen? *Please tick appropriate box*

Daily | Weekly | Fortnightly

How is this help needed?

8 Walking, getting about, care and support (person 3)

Full name of person with health problem

Is walking difficult? No ☐ Yes ☐

If YES, in what way?

How far can you walk on level ground? *Please tick appropriate box*

☐ Indoors only ☐ 10 yards/metres ☐ 200 yards/metres

☐ 1/4 mile/400 metres ☐ 1/2 mile/800 metres ☐ Over a mile/over 1500 metres

When moving about, is any of the following used? *Please tick appropriate box*

☐ Wheelchair ☐ Walking frame ☐ Crutches ☐ With assistance of another ☐ None

If you do, are these used indoors? No ☐ Yes ☐

How many stairs can you climb? *Please tick appropriate box*

☐ None ☐ 1-3 steps ☐ 8-12 steps ☐ 2 flights ☐ 3 flights

Do you need equipment to go up or down? No ☐ Yes ☐

Have you ever fallen when standing or walking? No ☐ Yes ☐

Do you leave home alone? *Disregard if the person is young child* No ☐ Yes ☐

If support care is provided, how often does this happen? *Please tick appropriate box*

☐ Daily ☐ Weekly ☐ Fortnightly

How is this help needed?

8 Walking, getting about, care and support (person 4)

Full name of person with health problem

Is walking difficult? No ☐ Yes ☐

If YES, in what way?

How far can you walk on level ground? *Please tick appropriate box*

☐ Indoors only ☐ 10 yards/metres ☐ 200 yards/metres

☐ 1/4 mile/400 metres ☐ 1/2 mile/800 metres ☐ Over a mile/over 1500 metres

When moving about, is any of the following used? *Please tick appropriate box*

☐ Wheelchair ☐ Walking frame ☐ Crutches ☐ With assistance of another ☐ None

If you do, are these used indoors? No ☐ Yes ☐

How many stairs can you climb? *Please tick appropriate box*

☐ None ☐ 1-3 steps ☐ 8-12 steps ☐ 2 flights ☐ 3 flights

Do you need equipment to go up or down? No ☐ Yes ☐

Have you ever fallen when standing or walking? No ☐ Yes ☐

Do you leave home alone? *Disregard if the person is young child* No ☐ Yes ☐

If support care is provided, how often does this happen? *Please tick appropriate box*

☐ Daily ☐ Weekly ☐ Fortnightly

How is this help needed?

9 Additional room for further information

10 Declaration - EACH person with a health problem MUST read and sign this declaration

Full name of person with health problem

The information you provide will be used for the purposes of your application for re-housing on health grounds. The information will be disclosed to the Health Advisors, designated staff with the Lettings Section and Occupational Therapists (if appropriate).

May we give information about you to other care agencies who need it in order to provide your care in connection with this application ? No ☐ Yes ☐

Do you give permission for your doctor or other Health or Social Services staff, who have been involved in your care, to release details about your health if we need to get information? No ☐ Yes ☐

Signature | Date

Full name of person with health problem

The information you provide will be used for the purposes of your application for re-housing on health grounds. The information will be disclosed to the Health Advisors, designated staff with the Lettings Section and Occupational Therapists (if appropriate).

May we give information about you to other care agencies who need it in order to provide your care in connection with this application ? No ☐ Yes ☐

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Signature | Date

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Do you give permission for your doctor or other Health or Social Services staff, who have been involved in your care, to release details about your health if we need to get information? No ☐ Yes ☐

Signature | Date

Full name of person with health problem

The information you provide will be used for the purposes of your application for re-housing on health grounds. The information will be disclosed to the Health Advisors, designated staff with the Lettings Section and Occupational Therapists (if appropriate).

May we give information about you to other care agencies who need it in order to provide your care in connection with this application ? No ☐ Yes ☐

Do you give permission for your doctor or other Health or Social Services staff, who have been involved in your care, to release details about your health if we need to get information? No ☐ Yes ☐

Signature | Date

Data Protection Statement

The information you give on this form will be stored on a computer. We have a duty to protect public funds, so to detect & prevent fraud we will share this information with other public agencies (viz. the Benefit Agency) & Council Sections (viz. Housing Benefits). To help you with your housing we will also share this information with other housing organisations & support agencies.

Beacon Authority
2004-2005
Early Interventions (Children at Risk)
2003-2006
Winner of 4 previous Beacon Awards

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

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