APPLICATION FOR MEDICAL PRIORITY

Main Housing Register Applicant Details		
Surname	**First Name(s)**	**Date of Birth**

Address	**Postcode**	**Home telephone number**

Mobile telephone number	
Work telephone number	
Email address	
Housing Register number (if known / available)	

Office use only

Housing Register Number	

Information for applicants completing the medical priority form

Based on the information provided in your application for housing, a medical priority form will, where required, be issued by the officer assessing your application. If you or a member of your household have an illness or disability that makes your home unsuitable, the Council's Medical Advisor will consider the information provided in this form and assess your need to move in accordance with the London Borough of Hammersmith & Fulham's Allocation Policy. Medical priority is only awarded on the grounds that the current housing situation of the homeseeker/ transfer applicant is having an adverse effect on their health or on the health of a member of their household and as a result, creates a particular need for them to move.

Medical priority will **not** be awarded on the following grounds:

- **Pregnancy** – unless it is considered that the current home of the applicant is adversely affecting the health of the pregnant woman and/ or the unborn child
- **Overcrowding** – unless it is considered that overcrowding is adversely affecting the health of the applicant or any person included on their housing application
- Minor illnesses, such as colds, flu, sprained ankle etc
- Poor conditions in your home, such as damp
- People who are adequately housed, such as wheelchair users living in ground floor single level access accommodation, which has had adaptations carried out that meet their needs.
- Conditions that are not permanently disabling e.g. limb fractures.

A letter from your General Practitioner or Consultant may not be required, however, any documentary evidence about your diagnosis or condition may assist your application. Please provide the names and addresses of all medical professionals from whom you are seeking treatment. We may write to them directly, should we require further information. We require your consent before we can request information from your doctor or anyone else treating you. Please ensure that you sign and date the section asking for your consent before submitting this Application for Medical Priority for assessment.

Important: Please read the whole form before you start to complete it.
You must answer all questions on this form, provide your signature where requested and date all sections as necessary, as incomplete forms will be returned to you. **Questions 5 onwards relate to the person in the household applying for assessment for medical priority.**

If more than one person is applying for medical priority assessment, please complete a separate form for each person.

Please make sure the information you provide on this form is true and complete.
If you have any doubts how to fill this form, please contact us via email housingregister@lbhf.gov.uk or telephone 020 8753 4198 option 1 option 1.

Failure to provide the requested information could result in the assessment of your application for medical priority being delayed.

2	Please indicate your current residential status:																			
Home owner		**Local Authority Tenant**		**Registered Provider (Housing Association) Tenant**		**Private rented tenant**		**Living with family or friends**		**Live with partner who is Local Authority tenant**		**Live with partner who is Registered Provider tenant**		**Live with partner who is private rented tenant**		**Other**		
If you have ticked "Other", please provide details below:																				

3	Property details of main applicant:							
Please circle the box that describes your home								
Flat	Maisonette	House	Sheltered Flat	Hostel	Bed-sit	Bungalow	B&B hotel	Other
If you circled “Other”, please tell us below what type of accommodation you occupy, e.g. caravan:								

On what floor is your front door?		If you live in a flat or maisonette, is there a lift in your block?	Y		N	
How many steps to your front door?		How many steps inside your property?				
On what floor is your bathroom?		On what floor is your W.C. (toilet)				

4 (a)	Current property details						
Please fully complete the table below to show rooms you have access to and whether they are shared:							
				SHARED?		IF SHARED - HOW MANY OTHER SHARERS	
		YES	NO	YES	NO		
Bedroom							
Bathroom							
Living room							
Toilet							
Dining Room							
Kitchen							

4 (b)	Sharing arrangements	
If you have stated that you share your current home with others, please state who they are:		

5	Please provide details of the member of the household applying for assessment for medical priority:			
Surname	First Name	D.O.B.	Do they live with you?	
			Yes	No
If you have answered "No" to the person applying for medical assessment as not living with you, please use the space below to tell us the reason you are living apart and go to question 5a. If you have answered yes, please go to question 6.				

5a	Where do they live?					
Address			**Postcode**		**Home telephone number**	
Please tick the box that describes their residential status:						
Owner-occupier		**Housing Association Tenant**		**Living with a friend or relative**		
Council Tenant		**Renting privately**		**Other**		
If you have ticked "Other", please provide details below:						

5 b	Have they been assessed for medical priority by this Authority before?	YES		NO	
If you have answered Yes, please stated date of previous assessment:					
If you have answered Yes, please state how the condition has changed since the previous assessment:					

6	Medical condition(s)	applies to the person named in Question 5 only

Please indicate the nature of the health problem(s) for the person named in question 5:							
Arthritis/ Stiff Joints		Diabetes		Heart Disease		Multiple Sclerosis	
Cancer		Stroke		Dementia		Phobia(s)	
Mental health condition		Asthma		Cerebral Palsy		M E	
Depression		HIV/Aids		Parkinson's Disease		Other	
Drug/ Alcohol addiction		Epilepsy		Lung Disease			

Please provide further details of condition(s) & how your current housing is affecting your health:

7	Details of treatment			
Have you seen your doctor about the illness you have detailed in q 6?	Yes		No	
Have you been referred to a hospital or clinic for specialist treatment?	Yes		No	
Use the space below to provide details of any treatment you are receiving or any medication that has been prescribed:				

8	Learning Disability	applies to the person named in Question 5

Does the person listed in question 5 have a Learning Disability?			
Yes		No	

Please provide further details of how your condition(s) is impacted by your current housing:

9	**Details of the professionals(s) treating you:**		
General Practitioner - Name & Address		**Hospital Dept/ Consultant/ Social Worker/ Occupational Therapist -** Name & Address	
Telephone Number		**Telephone Number**	
If you are receiving treatment/ support from more than one professional, please provide details:			
Name of service & Address:		**Name of service & Address:**	
Telephone Number		**Telephone Number**	

10	Disability or problems with mobility											
Are you registered disabled?					Yes		No					
Please indicate the nature of your moblity problem/ disability:												
Uses a wheelchair all the time				Uses a wheelchair outdoors but unable to climb steps				Walks with difficulty but can manage some steps				
Yes		No		Yes		No		Yes		No		
Has your current accommodation been adapted in any way to suit your disability?								Yes		No		
Please indicate the adaptation(s) that has/ have been made/fitted to your current accommodation:												
Ramp to front door		Walk-in shower		Grab rails in bathroom & W.C		Through-floor lift						
Stair lift		Lowered kitchen units		Widened doorways		Ground-floor W.C & shower						
Grab rails by stairs		Lowered light switches		Raised electrical sockets		Other						
If you have ticked “Other”, please provide details below:												

11	Personal Statement	
Please tell us about any other relevant factors that should be taken into consideration concerning the assessment of medical priority:		

12	Declaration

The London Borough of Hammersmith & Fulham is committed to the prevention and detection of fraud. Please read this declaration carefully before you sign and date it. Even if someone else has filled in this form, you must sign this declaration.

- **I confirm the information given on this form is correct and complete. I agree you can check the information.**
- **I understand you have a duty to protect the public money you look after. You may use this information to prevent and detect fraud, and may also share it with other organisations only for these purposes.**
- **Under section 6 of the Audit Commission Act 1998, the Council must take part in the National Fraud Initiative (NFI) data matching exercise. This means information we hold about you will be used for cross-system and cross-authority comparisons to prevent and detect fraud.**
- **We may use any information you provide in line with the Freedom of Information Act.**
- **I understand knowingly making a false statement could lead to legal action by the London Borough of Hammersmith & Fulham.**

Your signature	
Date	

Has this form been completed by someone who is not included on the application for housing?	**Yes**		**No**	

If you have ticked "Yes", please provide details below	
Name of the person who completed this form	
Relationship of this person to the main and/ or joint applicant	
Signature of the person	
Date	
Contact telephone number of this person	

13. Document Log

Please use this space to show any supporting documents you are providing along with this form e.g. GP letter

14	**Consent Form**	

I (*please print name)* _____, born on (*date of birth*) _____

of (*please print address)* _____
hereby consent to the London Borough of Hammersmith & Fulham being provided with information from any medical practitioner who at any time has attended to me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original. Sign_____

Date_____

Please return this completed / signed form and any supporting medical evidence to:

- By post or by hand: Housing Solutions, The Economy Department, 1st floor, 145 King Street, London W6 9XY.
- By email: Email your scanned form and evidence to housingregister@lbhf.gov.uk

16	*For staff use only* – Please ✓ and state reasoning				
Date form received		**Date assessed**		**Date if passed to CMA**	
Assessing staff member comments					
Date		**Signature**			
CMA Comments					
Date		**Signature**			