For office use only
Application reference:

West Of Scotland Housing Association Limited Health Assessment Form (Confidential)

Please note: If we award you medical points, we may restrict the type of property we offer you depending on your circumstances. N.B. A separate Health Assessment form must be completed by each member of the household affected by illness.

Name: .....

Address: .....

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Date of birth: .....

Relationship to applicant (if different): .....

1. What is your medical condition?

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2. In your own words, please tell us how this affects you.

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West of Scotland Housing Association

3. Is your condition temporary or permanent?

Please give details .....

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4. Do you, or will you, use a wheelchair?

Yes ☐ No ☐

5. In your current property are there any special facilities or adaptations?

Please give details .....

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6. Do you require any special facilities or adaptations in your new home?

Please give details .....

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7. Can you manage stairs?

Please give details .....

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8. Does the heating in your current property affect your health?

Please give details .....

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9. Does your condition mean you need an extra bedroom?

If yes, please give details .....

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Please note: We would require supporting evidence to consider your request for an additional room.

10. Do you have difficulty getting to shops and other local facilities?

If yes, please give details .....

11. Please describe how your present house is adversely affecting your health.

12. Please state how a move would change your situation (this must be directly related to your condition) and what kind of house you would require.

Please give:

Doctor's name: .....

Tel no: .....

Address: .....

Do you have an Occupational Therapist, Social Worker or Specialist?

Yes ☐ No ☐

If yes, please give details, e.g. name, job title, place of work and telephone number:

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DECLARATION

I hereby give permission to West of Scotland Housing Association Limited to ask my doctor/specialist/social worker, in confidence, for further information relating to the specific illness stated.

The information given in this form is, to the best of my knowledge, correct.

Name: ..... Date: .....
(Applicant signature)

Name: ..... Date: .....
(Joint applicant signature)

For office use only
Medical points awarded: ☐ Awarded by: ☐ Date awarded: ☐

Notes

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