

**APPLICATION FOR
ADDITIONAL HEATING
ON HEALTH GROUNDS -**

TO BE COMPLETED BY THE TENANT

Please read the guidance notes

This form will be used to assess your need and priority for additional heating on health grounds and should be forwarded to your local area services office. Please answer the questions as fully as you can, and circle the correct answer where you have a choice. A satisfaction form is enclosed for you to tell us what you think of this new procedure.

THE TENANT

NAME DATE OF BIRTH

ADDRESS

..... TEL. NO.

OTHER HOUSEHOLD MEMBERS

NAME	RELATIONSHIP TO TENANT	DATE OF BIRTH
.....
.....
.....
.....

Please state the name of the person/s who has/have a medical condition affected by your heating

.....

Please complete a separate PART 1 of this form for each person who has a medical condition affected by your heating.

PART 1 GENERAL HEALTH

NAME :

1. Please describe the nature or type of illness, disability or health problem/s, you /they have

.....
.....

2. Please describe why you feel your heating is unsuitable for your/their health needs

.....
.....

3. Do you/they have a specialist or are awaiting specialist referral? **YES / NO**

4. Have you/they had a hospital admission in the last year? **YES / NO**

5. Please list any medication or any treatment you/they receive (i.e. oxygen therapy, physiotherapy)

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.....

6. Do you/they have any mobility problems? **YES / NO** If **YES**, please indicate :

- Walk with a stick / aid **YES / NO**
- Use wheelchair indoors **YES / NO**
- Use wheelchair outdoors **YES / NO**
- Difficulty with stairs **YES / NO**
- Housebound **YES / NO**

7. Are you/they in receipt of any benefits including health benefits i.e. Disability Living Allowance Attendance Allowance, etc.? **YES / NO** If **YES**, which ones?

.....

If **NO**, would you like to receive some benefits information? **YES / NO**

8. Does your housing meet your/their health needs in other respects? **YES / NO**.
If **NO**, please describe (i.e. Unable to manage stairs, damp, disrepair)

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9. Please give details of your / their GP or specialist

Name :

Tel. No.

If there is no-one else in your household with a medical condition affected by your heating, please go to PART 2.

PART 2 PROPERTY

10. Please select one of the following property descriptions to describe the type of property you live in : *(please tick)*

- House (Please state number of floor levels)
- Bungalow (Note all rooms must be on same level)
- Maisonette
- Maisonette - multi storey (Note : more than 4 storeys)
- Flat (Note : all rooms must be on the same level)
- Flat - Multi-storey (Note : more than 3 storeys)
- Studio flat / bedsit (Note : combined living room/bedroom)

11. How many bedrooms do you have?

12. If you live in a flat, what floor level do you live on?

13a. Does your home suffer from

Dampness	YES / NO
Severe condensation	YES / NO
Widespread mould	YES / NO

If **YES** please specify which room/s

.....

13b. What affect has this had?

Increased use of heating	YES / NO
Made rooms unusable	YES / NO

If **YES** please specify which room/s

13c. Has your local office been informed? YES / NO
 Has any action been taken? YES / NO
 If **YES**, please describe

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14. Have you applied for rehousing? YES / NO
 If, **NO**, would you like more information? YES / NO

PART 2 HEATING

15a. Please complete the table below regarding the heating in your home - provided by the council. Please indicate what room the heating is in, what form and type.

ROOM	FORM	TYPE
<i>e.g. Living Room</i>	<i>Electric</i>	<i>Fire</i>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

15b. Please provide details of any other heating in your home provided by yourself :

.....

15c. Please provide any other relevant information regarding your heating

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CONSENT AND DECLARATION

Please read the following statements and sign if you are in agreement.

- (a) I have read the above information and agree that the information provided on this application form for additional heating or rehousing may be used to assess the level of priority awarded.
- (b) I authorise the city council to seek information from other agencies or health professionals if their advice is considered necessary.

Signature :

Date :