

BRISTOL HOUSING REGISTER

SHELTERED AND SUPPORTED HOUSING. HEALTH AND SUPPORT NEEDS ASSESSMENT FORM

Please use this form to tell us about any health or support needs that you or a member of your household may have that relate to your housing. **If there is more than one member of your family that you wish to tell us about please complete a separate form for each person.**

Details of person with needs

Full Name: Date of birth:

Current Address:

Telephone Number:

CONSENT AND DECLARATION *(please tick)*

- I agree to the information given by me on this form being used by Home Choice Bristol to assess my priority for rehousing.
- I agree that Home Choice Bristol can seek additional information from my Doctor, other agencies, or people who provide support, (listed on part 5 of this form) to assist my application for rehousing.
- I agree to the sharing of information that I have given, or that has been given about me, with relevant agencies on a 'need to know' basis and in accordance with Data Protection requirements.

Yes No

Signature:

Date:

OFFICE USE ONLY

Applicants name (If different from above): _____ Ref: _____

Applicants Address: _____

Part 1: Support needs

- Are you currently lonely or feel isolated? Yes No
- Would you benefit from assistance with filling in forms and dealing with letters and bills? Yes No
- Would you benefit from regular weekly face to face visits to check on your well being? Yes No
- Why do you feel you need sheltered/supported housing? _____

- Do you currently receive any care or support? Yes No
Please describe the type of care or support provided: _____

Approximately how many hours a day or week do you receive this? _____
Who is the main provider of this care or support? _____

If family or friend provide your help, what is their address?

How do they usually get to you? (e.g. Bus, drive own car, walk) _____

- Any additional information about your support needs? _____

Part 2: Current accommodation

In order to assess your banding priority on health grounds you need to complete this section

- **Current Housing facilities**

Do you live in a: House Maisonette Flat Mobile home

other (describe): _____

If you live in a flat which floor do you live on? _____

Is there a lift to this floor? Yes No

How many bedrooms do you have? _____

Do you have a second lounge or dining room? Yes No

How many toilets are there?. Upstairs Outside Downstairs

Do you have a Bath Shower

Do you have any problems accessing bathroom facilities? Yes No

If yes what? _____

- **Do you have any difficulties with stairs?**

Cannot manage at all Can manage with some difficulties /with help

How many steps are there from the backdoor to the garden? _____

How many steps are there from the road to the front door? _____

- **Do you have any disrepair problems at your property?** Yes No

If yes what? _____

If yes and you are a city council or housing association tenant has this been reported to your landlord or estate management team? Yes No

- **Do you have any problems with neighbours?** Yes No

If yes what? _____

- If yes and you are a city council or housing association tenant has this been reported to the city council estate management team or housing association? Yes No

- **Heating**

What type of heating do you have? _____

Which rooms have heating? _____

Is your heating adequate for your needs? If not please say why? _____

- **Parking**

Do you have a disabled parking bay outside you home? Yes No

If you have any parking problems please describe them: _____

- **Has your home already been adapted to help you?**

(eg. walk in shower, grab rails, ramps)

Yes

No

If yes please describe the adaptations that have been made: _____

Are you on a waiting list for adaptations?

Yes

No

What adaptations are you waiting for? _____

- **Storage of medical equipment** (eg. dialysis machine, hoist, oxygen)

Please describe any large items you currently use? _____

Do you have any storage problems? _____

Part 3: Your health problems

If there is more than one person in your household with health conditions that are a problem please complete a form for each one

- Please describe any current problems with your physical health

- Please describe any current problems with your mental health

- Please explain why you feel your current accommodation is unsuitable for your health needs?

- Do you attend a hospital clinic for any of the above problems? Please say which hospital and consultant you see

- Have you been a hospital inpatient in the last 5 years for these problems? Please say where, when and for how long?

- **Do you receive any care from community health care teams?** (eg district nurse, diabetic nurse, Occupational therapist or mental health services)

- **Do you currently take any prescribed medication? Please list here or enclose a copy of a prescription summary**

Mobility issues

- **If you have difficulty walking which of the following do you use?** (tick those that apply)

- | | |
|--|---|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Walking stick |
| <input type="checkbox"/> Self Propelled wheelchair | <input type="checkbox"/> Walking frame |
| <input type="checkbox"/> Motorised wheelchair | <input type="checkbox"/> Electric Scooter |

Other (please describe): _____

- **If you use a wheelchair where is it used?** (tick those that apply)

- | | |
|--|--|
| <input type="checkbox"/> Indoors only | <input type="checkbox"/> Both indoors and outdoors |
| <input type="checkbox"/> Outdoors only | |

- **For what distance, or for how many minutes, are you able to walk on the level before you need to rest?** _____

- **Do you have difficulty walking up hills or on a slope?** Yes No
Please describe problems in your local area _____

- **If you have access to a car please tick this box**

Who drives the car? _____

If you are the holder of a disabled blue badge please tick this box

- **Do you have a mobility scooter? If yes please tick box**

If so do you have access or storage problems? _____

- **Have you had any falls at home?** Yes No

Please describe how, where and when? How did you summon help?

- **Are you able to access public transport?** Yes No

- **Do you have any difficulties getting out of your property on a regular daily basis** (eg getting to shops, work or getting to appointments). Yes No

If yes how do you manage these tasks? _____

Part 4 – Details of people who currently provide you with help or support (Please complete)

	Their name & address	Telephone number	How often do you see them?	May we contact them for further information?
Your Doctor				
Hospital Consultant				
Support Worker				
Social Worker				
Home Carer				
District Nurse				
Health Visitor				
Community Nurse				
Psychiatric Nurse				
Occupational Therapist/Aide				
Relative				
Friend				
Other				

Part 5: Other information

Do you currently receive any benefits? Tick those that you receive and circle the rate.
(You may be asked to provide evidence of benefits)

Disability Living allowance – Mobility Component High or Low
Disability Living allowance – Care Component High, Medium or Low
Attendance allowance High or Low
Carers allowance

Other (please specify): _____

- **We may need to visit you to assess your priority – is there a relative, friend or support worker who you would like to be present if this is the case?**

Name: _____

Relationship: _____

Contact Details: _____

- **Has anybody helped you to fill in this form?** Yes No

If yes, please give details and contact number: _____

- **Would you like information about Piper alarm or Home Support Line?** Yes No

- **Have you applied to Adult Community Care for Very Sheltered Housing?** Yes No

If no - would you like us to send you some further information? Yes No

Please use this space to tell us anything else about your current health and housing problems not already covered in your answers so far
