

Solihull Home Options Medical Assessment Questionnaire

For problems due to neighbour nuisance, repairs or damp please call 0121 7171515 for advice in the first instance as we may not consider these as medical issues.

Proof of a valid close association to Solihull Borough must be provided to allow the Medical Assessment Questionnaire to be processed.

Applicant D	Details					
Name						
Date of birth						
PIN						
Address					Postcode	
Telephone nu	umber					
Current prope	erty type				<u> </u>	
If flat please	advise of floo	or				
Lift	Yes 🗖	No 🗖				
			., .,			
Name of pe	erson with r	nedical condition	n if different fr	om applicant		
Telephone N	umber	-				
Date of birth						
	Mala 🗖	Famala D				
Gender		Female 🗖	dition have a c	consultant?		
Gender Does the pe				consultant?		
Gender Does the pe	erson with	the medical cond		consultant?		
Does the pe	erson with	the medical cond		consultant?		
Does the pe	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		
Does the period of the period	erson with No umber	the medical cond		consultant?		

	How does the current accommo	dation affec	t tilelin		,		
f							
F							
F							
F							
ŀ							
	Proof of your medical condition and v professional i.e. G.P or Consultant Sp Your application will not be processed	pecialist. We h	ave atta	iched a tear of			vided from a
,	Why would alternate accommod	dation help y	ou/thei	r condition?			
ŀ							
F							
-							
ŀ							
L							
ſ							
	Do you need to give or receive s		n anoth	er person wh	no lives in Solihu	II?	
		support from	anoth	er person wh	no lives in Solihu	II?	
,			anoth	er person wł	no lives in Solihu	II?	
,	Yes □ No □ If yes ple		n anoth	er person wl	no lives in Solihu	II?	
,	Yes No If yes ple Name Address	ase provide					
,	Yes No If yes ple	ase provide			no lives in Solihu		
	Yes No If yes ple Name Address	ease provide					
	Yes No If yes ple Name Address Post Code	ease provide					
	Yes No If yes ple Name Address Post Code	ease provide					
	Yes No If yes ple Name Address Post Code	ease provide					
	Yes No If yes ple Name Address Post Code What support do you give or receive?	ease provideRelationship	p to you				
	Yes No If yes ple Name Address Post Code	ease provideRelationship	p to you				
	Yes No If yes ple Name Address Post Code What support do you give or receive? Does the person with the medic professional?	Relationship	p to you				
	Yes No If yes ple Name Address Post Code What support do you give or receive? Does the person with the medic professional?	ease provideRelationship	p to you				
	Yes No If yes ple Name Address Post Code What support do you give or receive? Does the person with the medic professional?	Relationship al condition ase provide	p to you				
	Yes No If yes pleady	Relationship al condition ase provide	p to you	n Occupatio			
	Yes No If yes pleady	Relationship al condition ase provide	p to you have a	n Occupatio			
	Yes No If yes pleady	Relationship al condition ase provide	p to you have a	n Occupatio			
	Yes No If yes pleady	Relationship al condition ase provide	have a	n Occupatio	nal Therapist or o		
	Yes No If yes pleady	Relationship al condition ase provide n your curre	have a	n Occupatio one Number ne?	nal Therapist or o		
	Name Address Post Code What support do you give or receive? Does the person with the medic professional? Yes No If yes please Name What adaptations do you have in the professe advise of type	Relationship ase provide ase provide n your curre Yes Vertical	have a	n Occupatio one Number e? No Stair lift	nal Therapist or o		
	Name Address Post Code What support do you give or receive? Does the person with the medic professional? Yes No If yes please Name What adaptations do you have in the support of the person with the medic professional? What adaptations do you have in the support of the person with the medic professional?	Relationship ase provide ase provide n your curre Yes Vertical Wet Room	have a	n Occupatio one Number ne? No Stair lift Step in	nal Therapist or o		
	Name Address Post Code What support do you give or receive? Does the person with the medic professional? Yes	Relationship al condition ase provide n your curre Yes Vertical Wet Room Yes	have a	n Occupatio one Number e? No Stair lift Step in No	nal Therapist or o		

_ift	Yes		No			
f yes please advise of type	Vertical		Stair lift			
Shower	Wet Room		Step in			
Grab rails	Yes		No			
Wider doors	Yes		No			
Ramp	Yes		No			
Do you use a wheelchair ins	side your proper	ty?				
	Yes		No			
Marie barre a disability / mal	hilita : i a a		dataila ta a		Occupational Thereniat	
If you have a disability / mol	bility issues we ma	y reter y	our details to d	our Housing	Occupational Inerapist	
Do you take medication? If s	so please list be	low wit	th details of	dosage an	d daily intake	
-			_		_	
Medication			Dosage		Frequency	
		=				
		-				
		=	-			
		_	-			
		=	-			
		=				
		_				
		_				
		_				
		_				
		=				
		=				
Proof of medication must be prov	ided with complete	d quest	ionnaire which	must be no	more than	
3 months old Please provide your NHS Number						
Touse provide your Wild Humber				 ;		
Please tick below what bene	efits you are cur	rently i	n receipt of	or advise i	f employed	
Employed						
Jniversal Credit						
J.S.A	_					
E.S.A./ Incapacity Benefit	_					
D.L.A.	_					
J.L.A.	•					
P.I.P.						

Declaration

Please check the information you have provided is correct. Please read the following statements before signing the declaration.

I/We declare that, to the best of my/our knowledge that the information supplied on this form is correct and that I/We will inform Solihull Home Options, Solihull Council, Solihull Community Housing or the partner housing associations of any changes in my circumstances.

I/We understand that under the Housing Act 1996 section 171 that it is an offence to make a false statement, either knowingly or recklessly, to a local authority in connection with any request for housing assistance.

It is also an offence to withhold information, which is requested by Solihull Home Options, Solihull Council, Solihull Community Housing or the partner housing associations

I/We understand that any person found guilty of an offence under this section is liable to a fine of up to £5,000.

Where a tenancy has been granted and it is later found that false or misleading information has been given or information has been withheld, the Council or partner housing associations may commence possession proceedings for the recovery of the property. In these circumstances I/We may lose the right to be re-housed by Solihull Council and partner housing associations.

I/We understand that Solihull Home Options, Solihull Council or Solihull Community Housing and partner housing associations make enquiries regarding this application

Signature: Date:	
For completion by your GP Consultant or Other Medical Profes	ssional
Applicants Name	
Address	
What medical condition/diagnosis does he/she have	
2. What treatment is he/she receiving	
Will this medical condition improve with alternative housing	g? If so how?
Date	Courses Address Charac
Date: Signature	Surgery Address Stamp
Full name	
Profession:	