



A fresh approach to people, homes and communities



If you need help understanding this information, please ask one of our staff, or phone the number on the attached letter.

আপনার যদি এই তথ্য বোঝার জন্য সাহায্যের প্রয়োজন হয়, তবে অনুগ্রহ করে আমাদের কোন একজন স্টাফকে জিজ্ঞাসা করুন, অথবা গ্রাহক পরিসেবায় যোগাযোগ করুন।  
টেলিফোন 01226 772720

अगर आप इस जानकारी को समझने में सहायता चाहते हैं तो कृपया हमारे किसी कर्मचारी से पूछें, या उपभोक्ता सेवा, टेलीफोन 01226 772720 पर संपर्क करें

Jeśli nie rozumieją Państwo tych informacji i potrzebują pomocy, mogą Państwo poprosić o pomoc kogoś z naszych pracowników lub zadzwonić pod numer telefonu: 01226 772720 (Biuro Obsługi Klienta)

Если вам требуется помощь в понимании этой информации, обратитесь к нашим сотрудникам или позвоните в Отдел обслуживания клиентов по телефону 01226 772720.

اگر برای درک این مطالب نیاز به کمک دارید، از یکی از کارکنان ما کمک بخواهید، یا با بخش خدمات رسانی به مشتریان ما تماس بگیرید، شماره تلفن 01226 772720

اگر آپ کو ان معلومات کو سمجھنے کے لئے مدد کی ضرورت ہے، تو براہ مہربانی ہمارے عملے کے کسی رکن کو پوچھیں، یا کسٹمر سروسز سے رابطہ کریں، ٹیلیفون 01226 772720

إذا كنت بحاجة للاستفسار عن هذه المعلومات، رجاء اطلب المساعدة من احد الموظفين او اتصل بخدمات الزبائن على الرقم 01226772720

如果您需要协助，以便更好地了解该信息，请与我们的员工联系，或致电客户服务：01226 772720。



Corporate member of  
Plain English Campaign  
Committed to clearer communication.

231



Berneslai Homes Limited is a company controlled by Barnsley Metropolitan Borough Council. It is a company limited by guarantee, registered in England and Wales, number 4548803. Registered office: Springfield House, Springfield Street, Barnsley, S70 6HH. www.berneslaihomes.co.uk

# Medical self- assessment form



A fresh approach to people, homes and communities

Please return to:

Housing Assessment Team, Berneslai Homes, PO Box 627, Barnsley S70 9FZ.

Office use only

Surname

First name

Reference number

## Who can apply for medical priority?

Anyone who has a physical or mental-health condition can apply for medical priority. We will only give priority to people who are at risk in their current home and whose circumstances could be improved by being rehoused.

## Do I need to get a letter from my doctor or hospital?

No. If we need more information to make a decision about your application, we will contact the relevant person. You must give us permission to do this.

## How will you assess my medical priority?

You need to fill in this form so we can make a decision. If you need help, call into any Barnsley Connects Office, or phone us on 01226 775555. We will refer your case to a medical assessment officer, who may carry out a home visit to help us make a decision. We will make a decision within 10 days of receiving all the information we need.

## How do you decide priority?

Before making a decision on priority we look at your circumstances, and whether you are able to sort out your own situation. We look at whether your housing affects your wellbeing, and how you manage daily activities. We only give medical priority if rehousing will improve your health or wellbeing.

We give four levels of priority - the highest is band 1, the lowest is band 4. The bands are based on the level of risk to you in your current home. If you qualify for priority, we give it from the date you asked us to consider your medical condition.

We will also give you information on other housing options available to you and whether the type of property that you need is available.

## What should I do if my circumstances change?

You need to let the Housing Assessment Team know. They will assess your application again and decide whether this will affect your priority.

## What can I do if I am unhappy with the decision you have made?

You can appeal against our decision. For more information see our leaflet 'Homeseeker', which you can get at any Barnsley Connects Office.

Please fill in all sections.

## Section 1 – General information

Your name	Age
-----------	-----

Address
---------

Phone number: Home	Mobile
--------------------	--------

E-mail address
----------------

Are you currently waiting to leave hospital?  Yes  No

If 'Yes', what is the name of the hospital?	Ward number
---	-------------

Give the name of your social worker (if you have one)
---

## Section 2 – Who in your household needs to move for medical reasons?

Name	Relationship to you	Date of birth	Name, address and phone number of their doctor, social worker or community psychiatric nurse
		/ /	
		/ /	
		/ /	
		/ /	

## Section 3 – What physical conditions do you have which you think would improve if you were rehoused?

(If you have a mental-health condition, please fill in Section 10.)

Please list all relevant physical conditions and tell us whether you are receiving treatment, for example, medication, or outpatient or physiotherapy treatment. If you need more space, please use the notes section on page 7. Give us this information for everyone who lives in your home.

Name	Physical condition	Are you having treatment?	If 'Yes' please give details.
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Section 4 – How are these physical conditions made worse by your current home?

For example, you cannot climb stairs. If you need more space, please use the notes section on page 7. Give us this information for everyone who lives in your home.

Name	Difficulties

## Section 5 – Do you have any of the following in your home?

Please tick all that are relevant.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bath                             | <input type="checkbox"/> Toilet upstairs   | <input type="checkbox"/> Ramp                |
| <input type="checkbox"/> Shower over bath                 | <input type="checkbox"/> Toilet downstairs | <input type="checkbox"/> Stairlift           |
| <input type="checkbox"/> Step-in shower or shower cubicle | <input type="checkbox"/> Bath downstairs   | <input type="checkbox"/> Through-floor lift  |
| <input type="checkbox"/> Level-access shower or wet room  | <input type="checkbox"/> Shower downstairs | <input type="checkbox"/> Ceiling track hoist |

## Section 6 – How would you describe your mobility within your home?

Tick the boxes that best describe your current difficulties in getting around.  
(Please note: equipment includes bath boards, bath lifts, grab rails and so on.)

### Climbing stairs

- I have no difficulty.
- I have difficulty but manage without help.
- I manage with the help of the banister rail.
- I rely on someone to help.
- I cannot manage at all and live downstairs.

### Access to toilet or washing facilities

- I have no difficulty.
- I have difficulty but manage without help or equipment.
- I manage with equipment but without help.
- I rely on someone to help.
- I live downstairs and cannot get to the toilet or bathroom.

## Section 7 – How would you describe access to your home?

Tick the boxes that best describe your current difficulties.

Has your property got steps outside?  Yes  No

If 'Yes', please tick the relevant box below.

- I can climb these steps without any help.
- I manage with handrails and equipment I already have.
- I cannot manage without help from someone.

### How do you manage getting into and out of your home?

- I have no difficulty.
- I have difficulty but manage without help.
- I manage using ramps or rails I already have.
- I rely on someone to help.
- I am housebound (cannot leave my home).

### How are you at walking?

- I am fully mobile (can get around easily).
- I can walk to the nearest bus stop or shop without difficulty.
- I use walking aids or manage with help.
- I use a motorised scooter.
- I rely on a wheelchair outside.
- I rely totally on a wheelchair.

## Section 8 – How do you manage your daily living?

Please tick all the boxes that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> I do all my own shopping.                   | <input type="checkbox"/> I do my own cleaning.            |
| <input type="checkbox"/> I can do light shopping.                    | <input type="checkbox"/> I can do light cleaning.         |
| <input type="checkbox"/> Someone helps me do light shopping.         | <input type="checkbox"/> I have help with my cleaning.    |
| <input type="checkbox"/> I am unable to do any shopping or cleaning. | <input type="checkbox"/> I am unable to do any housework. |

## Section 9 – Support

If you receive support, please tell us who provides it and give us their details.  
(If you do not receive support please go to section 10.)

	Name	Address and phone number	What support is provided?	How often, for example every day, every week
<input type="checkbox"/> Family				
<input type="checkbox"/> Friends				
<input type="checkbox"/> Council's home-care service				
<input type="checkbox"/> Agency care services				
<input type="checkbox"/> Social worker				
<input type="checkbox"/> Other (give details)				

If necessary, use this space to give more information.

## Section 10 – What mental-health conditions do you or your family have which you think would improve if you were rehoused?

Does anyone in your household have a mental-health condition?  
(If 'No' go to section 11.)

Yes

No

Who in your household has a mental-health condition?

What is the name of their condition?

What are their symptoms?

How long have they suffered from this condition?

Have they been in hospital for this condition in the last two years? (Please give details.)

Do they receive treatment?  
(for example, medication, counselling, outpatient treatment?)

Yes

No

If 'Yes', please give details.

Do they receive support from any agencies  
(for example, community mental-health team or voluntary organisation)?

Yes

No

If 'Yes' please give details.

Why do they want to move?

How do they feel a move will improve their mental health?

Name of social worker

Phone number

Name of consultant, hospital doctor or GP

Phone number

Name of community psychiatric nurse

Phone number

## Section 11 – Referrals to medical professionals

We may need more information about your medical condition. Please sign below to give your doctor or any health professional permission to provide information to our medical assessment officer.

Signature	Date / /
-----------	----------

### Confidential

Patient's name	Patient's address
----------------	-------------------

Dear Doctor

The patient above has applied for rehousing for medical reasons.

We need to carefully assess the priority of people who apply to make sure we help those people whose needs are most urgent. So, we are asking you to confirm the extent of their medical condition and how suitable their present home is.

If a move would sort out or help their medical condition, please say how or why. Please also consider what degree of risk we should give to this case.

### We will not release any information to your patient without permission.

Do you give us permission to give your patient information?  Yes  No

Please tick the most relevant priority.

<input type="checkbox"/> Band 1	Immediate risk
<input type="checkbox"/> Band 2	Very high risk
<input type="checkbox"/> Band 3	High risk
<input type="checkbox"/> Band 4	Low risk and a move to different accommodation would not sort out or help their medical condition
<input type="checkbox"/>	The applicant would prefer to move but doesn't actually need to

Please give reasons for your suggested priority.

Your signature	Date / /
----------------	----------

Please note: We can override any recommendation if necessary (depending on the circumstances of the person applying for rehousing).