

Thurrock Housing Health Questionnaire for Rehousing

Case reference

Section 1 Part A *Where you live now*

Please use block CAPITAL letters throughout the questionnaire.

1. Surname of main applicant Date of Birth

Forenames Male Female

Current Address

 Postcode

Home phone number

Work phone number

Mobile phone number

Email Address

If someone else (e.g. a relative, friend or an organisation) is handling this application on your behalf, please give the name, address and telephone number of the person to be contacted about this application.

Name

Address

 Postcode

Home phone number

Work phone number

TO BE COMPLETED BY ESTATE OFFICER ONLY

Name of Officer

Office

Contact number

Section 1 Part B About your home

2. How long have you lived at this address? Under 6 months Under 5 years
Under 1 year 5 years or longer

3. Are you on the Housing Registration list? Yes No

4. What kind of accommodation do you have? House Flat
Maisonette Town house
Warden controlled property Bungalow

- If applicable, what floor is your home on? Basement Ground
1st Floor 2nd Floor
3rd Floor 4th Floor
Other (please specify)

5. Is your accommodation
Owned by you Privately rented Council property Housing association
Other (please specify)

6. Please state how many bedrooms your property has

7. Do you have steps to get into your home? Yes No
If yes, please state how many

8. Do you have stairs inside your home? Yes No
If yes, please state how many

9. Are the stairs straight or curved? Please state

10. Do you have a stair lift? Yes No

11. Is there a handrail running along your stairs? Yes No
If yes, please state if this is on the left side, right side or both

12. If applicable, is your home in a block with a lift? Yes No

Does the block have a second lift? Yes No

13. What kind of heating does your home have?

14. Which rooms (if any) have no heating? (Please tick all that apply)

Bathroom Bedroom Kitchen Hallway/Corridor Toilet

Living/Sitting room Other (please specify)

15. Are there any rooms that you are unable to get to in your home? (Please tick all that apply)

Bathroom Bedroom Kitchen Hallway/Corridor Toilet

Living/Sitting room Other (please specify)

Section 2 *About your health condition*

Please complete an **additional section 2** for each member of your household who has a severe or chronic health condition, which makes your home difficult to live in.

16. Surname Date of Birth

Forenames Male Female

17. Weight Height

18. Are you visually impaired? Yes No

If yes, please state help needed

19. Do you have a hearing impairment? Yes No

If yes, please state help needed

20. Please state what your current health problems are. Include your diagnosis if known. Please give as much information as possible to enable us to make an informed decision e.g. Doctors letters and Hospital discharge letters. Please continue on a separate sheet of paper if necessary.

1.

2.

3.

4.

5.

6.

21. Please state WHY your health condition makes your home unsuitable for you to live in. If you believe you will be homeless in the near future please explain why. Please continue on a separate sheet of paper if necessary. **PLEASE NOTE: Your questionnaire will be invalid if no information is entered.**

22. Please list the medicines or drugs you are taking and enclose a Photostat copy of your prescription sheet if possible. Please continue on a separate sheet if necessary.

Name of medicine	Reason	Dosage	Form of drugs i.e. syrup, tablet

23. How long have you had your health problem? Under 6 months Under 5 years
 Under 1 year 5 years or longer

24. Have you spent time in hospital or residential care in the last 3 years? Yes No

If yes, please give details in the table below. Please continue on a separate sheet if necessary.

Name of hospital or care home	Reason (Treatment you were having)	Dates (To and from)

25. Are you attending day hospital or having appointments for your condition? Yes No

If yes, please give details in the table below. Please continue on a separate sheet if necessary.

Name of hospital	Reason (Treatment you are having)	How often you attend

26. Do you receive any help at home for your condition? Yes No

If yes, please give details below of who helps you and what service they provide e.g. District Nurse, Home Care, Meals on wheels etc. Please continue on a separate sheet if necessary.

Section 3 *About your mobility*

27. Do you have difficulty using a lift? Yes No

If yes, please state why

28. Do you have difficulty walking up a flight of steps? (12-14 steps) Yes No

Please state the number of steps you can manage

Please state what your difficulties are in climbing steps

29. How far can you walk unaided on level ground?

I cannot walk at all No more than 9 metres No more than 27 metres No more than 90 metres

CHECKLIST FOR APPLICANTS

Please complete the checklist before posting or handing in your completed housing health questionnaire.

Have you completed:

• Section 1- Part A (Where you live now) and Part B (About your home)? Yes No

• Section 2 - About your health condition? Yes No

Have you completed ONE Section 2 for each member of the household whose health is affected by the current home? Yes No

If yes, please state how many copies of Section 2 are enclosed

• Have you provided additional information that may help the Council when reviewing your case? Yes No

Please provide details

PLEASE NOTE YOU ARE ADVISED TO:

- State how your current housing is affecting your health (See Question 21) as failure to do so may invalidate your application
- Sign and date the **DECLARATION** below
- Sign and date **AUTHORISATION OF SHARING INFORMATION** to confirm that you agree the Council may share the information. If you have not agreed to this, please state your reasons below.

DECLARATION

I declare that the information provided is true and complete.

Signed..... Date.....

AUTHORISATION OF SHARING INFORMATION

The following are agencies and people who are generally able to help. Please indicate those which you agree the Council can contact to share appropriate information.

Nurse or General Practitioner Housing department Hospital Doctors/Nurses

Social services Community Nurses or Therapists

Department for works and pensions

I consent that the information detailed on my application can be shared with those people and agencies agreed above.

Signed..... Date.....

Name and address of your General Practitioner

Postcode

Telephone