



1. Details of applicant with medical condition, applying for Housing Assistance

Full name of applicant

Applicant's address

Postcode

Date of birth

Authorisation of applicant with medical condition

I give permission for medical details affecting my need for housing to be released to Women's Housing Company and, if necessary for my doctor/health care professional to discuss these details on my behalf with a staff member of Women's Housing Company.

I have read and understand the following notice.

Notice

This is a notice under the Privacy and Personal Information Protection Act 1998 (PPIP Act) which governs the collection, security, use and disclosure of personal information and health information respectively. Women's Housing Company collects personal information including health information in order to provide services to you. The supply of information by you is voluntary. If you cannot or do not wish to provide the information Women's Housing Company may be unable to process your application. The intended recipients of your information include those involved in the administering of your housing application or tenancy or any other who may have an interest in considering your application or tenancy including where relevant Community Housing Division of Housing NSW, Housing Appeals Committee or a community housing provider and survey companies for the purpose of determining client satisfaction and related long term service enhancement. In the case of unpaid debts your information may be passed onto a third party to assist in debt recovery. Women's Housing Company may disclose information to other government agencies or statutory bodies for purposes including child protection, health reasons, law enforcement and investigation, where authorised to do so under the PPP Act, HRIP Act, or by another Act or law. You have the right of access to, and correction of, your personal information held by Women's Housing Company to ensure it is accurate and not misleading. If you have any questions about privacy and your personal information, please contact Women's Housing Company.

Name – please print

Signature

Date: / /

2. To the Health Care Professional

The above client/patient has presented to Women's Housing Company requesting Housing Assistance or Housing Transfer. Women's Housing Company is committed to allocating suitable housing for applicants so that sustainable tenancies can be created. Your completion of this Medical/Health Assessment form will ensure that all relevant facts pertaining to the client's medical condition are considered prior to allocating housing.

This information will ensure your client's needs for housing, particular housing features, type or location will be accurately assessed.

To assist in this process the following information is required.

Details of Health Care Professional completing this form.

Name

Practitioner's address

Postcode

Practitioner's telephone number

Provider Number

Are you a:

- General Practitioner
- Specialist
- Allied health worker

What is your field of expertise?

Practitioner's signature

Date

3. Length of association with the patient

- One consultation only
- Weeks
- Months
- Years

4. Do you feel it would be necessary to discuss the patient's details further with Women's Housing Company?

- No
- Yes

5. Please provide details of the patient's medical condition/s which support their application for wait turn/ priority housing/ housing transfer assistance.

1. Name of medical condition

General description of condition

2. Name of medical condition

General description of condition

3. Name of medical condition

General description of condition

4. Name of medical condition

General description of condition

6. What is the overall impact these condition(s) has on the patient's well being?

- Minor impact
- Moderate impact
- Severe impact
- Very severe impact

7. Is the condition(s) likely to have long term implications for the patient?

- No **Go to 9**
- Yes (Go to next question)

8. How long are the implications likely to last?

- Short (0 – 2 years)
- Medium (2 – 5 years)
- Long (5 years or more)

9. Indicate the frequency of visits the patient is required to make to access health related services/facilities.

Tick one only

- Daily
- Couple of times per week
- Once a week
- Once per fortnight
- Once per month
- Couple of times per year

10. Indicate the length of visits the patient is required to make to access services /facilities on each occasion.

Tick one only

- Under an hour
- Couple of hours
- Full day
- Few days
- Weeks
- Other (give details)

11. Is the patient able to access services /facilities by walking or by taking public transport?

- No (give details)
- Yes (go to next question)

12. Is the current house exacerbating the client/patient's condition (eg room for medical equipment)

No
Yes (give details)

13. What type of housing does the client /patient require due to their condition?

14. Does the condition(s) relating to the client/patient affect their ability to look for suitable/affordable housing?

No
Yes Explain how

15. Is the client/patient subject to extra expenses because of their medical condition(s)?

No
Yes List the expenses incurred on a regular basis by the client which cause financial hardship.

16. Does the client need to live in a particular area to access support services?

No **Go to 19**
Yes List support services presently used to substantiate locational need

17. What location is required?

18. Is there a second suitable location?

No
Yes (give details)

19. Is the patient/clients mobility restricted?

No **Go to 24**
Yes

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20. Does the client/patient need ground floor accommodation only?

No
Yes (give details)

21. Does the client/patient require modified housing?

No
Yes (give details)

22. Can the client/patient manage steps?

No
Yes (How many?)
0 1-2 3-5 6 or more

23. Are there any other mobility restrictions?

No
Yes Explain how these effect their housing

24. Does the client/patient have difficulty with independent living skills (eg can cook, clean and shop for self)?

No **Go to 29**
Yes

25. Has an independent living skills assessment been done?
No
Yes Please attach the independent living skills assessment

26. Does the client/patient need a carer?
No **Go to 28**
Yes

27. Does the client/patient have a carer at present?

No How long before needed?

Yes Is the carer: Full Time
 Part time
 As needs basis

If part time or needs basis how many hours per day/week and is over night care required?

28. Does the client/patient need regular support?

No
Yes list support

29. Does the client have any psychological issues which affect their ability to cope?

No **Go to 33**
Yes

30. Does the condition(s) require medication for the client/patient to live independently

No
Yes (give details)

31. Is the condition supported by other health professionals?

No
Yes Who provides this support?
Tick all that apply

Mental health workers
Counsellors
Psychiatrist
Other health professional (give details)

32. Does the client/patient have particular dwelling requirements as a result of the condition?

No
Yes Describe dwelling requirements

33. Is the client/patient currently housed inappropriately?

No
Yes

34. Would you like to add further comments to support the patient's needs?

No
Yes (give details)

35. Checklist

If appropriate, have you attached copies of relevant documentation such as:

- Independent living skills assessment
- Occupation Therapist's report detailing modifications

Thank you for taking time to assist your patient by completing this questionnaire.