APPLICATION FOR MEDICAL PRIORITY

This form is to allow all applicants to Langstane Housing Association to apply for medical priority to be considered with their application.

Medical priority will only be awarded where the medical condition of the applicant or any person moving with the applicant is made worse and will continue to be made worse if they remain in their present accommodation. Any request for alternative accommodation must assist with the improvement of the medical condition.

All relevant information should be completed on this form and signed off (and stamped) by the medical professional involved with the treatment of your condition.
Authorised signatories are: -

- Doctor
- Consultant
- Specialist Nurse

Unsigned and unstamped forms or those signed by any other person will not be accepted or considered for priority.

There are 4 categories for medical grounds: -

- No Effect – 0 Points – The applicant has no medical condition or the condition would not be improved by the allocation of alternative housing.
- Moderate Effect – 5 Points – The applicant has a condition that although it is not severely affected by the housing, they would benefit from being offered alternative housing.
- Significant Effect – 10 Points – The applicant's medical condition is adversely affected by their current housing and this will only be improved by moving to suitable alternative accommodation.
- Severe Effect – 15 Points – By remaining in the current home the applicant has a loss of independence and there is a risk to their personal safety. The applicant cannot occupy their home.

Once this form has been received by Langstane Housing Association an assessment will be made and a decision made within 5 working days.

If there is more than one person on the application with a medical condition, one medical form is required for each person, although only one award of priority will be made to the highest priority.

Should you wish to discuss this process, please contact us on 01224 423000.

Langstane Office Use Only

Date Received:

Date App Updated:

Priority Awarded:

No Low Med High

APPLICATION FOR MEDICAL PRIORITY

This form is to be completed to support your application for housing on medical grounds. Medical points will only be allocated where your condition (or that of a member of your household) is worsened by living in your current home and would be improved by the allocation of alternative housing.

This application will not be considered unless signed and stamped by your own Doctor, Consultant or Specialist Nurse only.

Application No:

Applicant Name:

Current Address:

Name of person applying for Medical Priority (if different from above):

Date of Birth:
(Person applying for Medical)

Medical Details

Name of Medical condition	Details of Medication/treatment in dosage	How is the condition worsened by your current housing situation?

Doctor / Consultant Name:

Surgery Address:

Other information. If there is anything else that you would like to add to this application please supply details below:

Declaration:

i. **I agree that to the best of my knowledge all the information provided in this form is true and accurate. If I knowingly supply any false information or omit relevant information my application may be cancelled or suspended.**

ii. **Under section 40 of the Housing (Scotland) Act 1987, I understand that it is an offence to knowingly provide false information or omit relevant information which leads to an offer of a tenancy. In such circumstances, the landlord may take steps to terminate the tenancy.**

iii. **Langstane Housing Association will not accept any abuse or threatening behaviour towards their staff.**

iv. **I confirm that I will notify Langstane Housing Association of any change to my medical condition and resubmit a medical form if required.**

v. **I confirm that in no way is Langstane Housing Association responsible or liable for any charges raised by the Doctor/ GP / Medical Practice for the appointment/ consultation that led to the signing of this form.**

Signed (Applicant):

Date:

TO BE COMPLETED BY DOCTOR / CONSULTANT.

i. **I confirm that the information supplied within this form is a true record of my patient's condition and the effect their housing has in relation to their medical condition.**

Signed (Doctor/Consultant):

Date:

Surgery Stamp: