Housing Functional Assessment Form

Please read this before you fill in the form.

In line with our Allocations Policy, we award points for housing to applicants based on their current housing circumstances.

If you think that you or a member of your household's health and/or disability is being made worse by your current housing situation, you can apply for a functional assessment.

This is not an assessment of the severity of a clinical condition or disability.

It is an assessment of the need for another home that would either help to stabilise a clinical condition or disability, or allow a person to function more independently. It is about the way the condition affects how the person manages at home. It focuses on the person's ability, or inability, to perform essential day to day tasks within their home.

The definition of disability that we use to make our assessment is detailed in the Equality Act 2010. It will be updated in line with any changes in legislation. The Equality Act 2010 defines disability as a physical (including sensory) or mental health impairment which has had a substantial or long term adverse effect upon a person's ability to perform normal day to day activities.

The functional assessment will consider:

- if and why your current home is not suitable or if it would be unsuitable to adapt; **or**
- if rehousing is essential to maintain longer term health, welfare or independence of the person; **and /or**
- if health and welfare or independence could be significantly or moderately improved by re-housing; **and/or**
- if reasonable and practical adaptations can be made to the property, but rehousing would meet longer term needs more fully and efficiently.

The assessment will take into account the following aspects of daily living:

- mobility (how easy it is for you to move around);
- access (getting in and out of your home and rooms in it, and getting to necessary equipment and facilities in your home);
- stairs;
- transfers (for example, getting in and out of bed);
- personal care (washing, dressing and so on);
- domestic tasks; and
- social interactions.

Guidance on filling in the functional assessment form

If you need any help with this form please phone us on:
0300 123 4566.

What you need to do:

- Please try to answer all of the questions. We will use the information you give us to assess your household's housing needs. If you need more space, please use **page 22** of this form.
- Please give us as much detail as possible to help us make our assessment. If you have any supporting information that will help with the functional assessment, you can also send it to us. For example, if you have information from your doctor, consultant, mental health professional or a social worker.

What happens next?

- The Housing Occupational Therapist or other officer will complete the assessment. If we need more information, we will contact you. This will determine if any points can be awarded under our Allocations Policy.
- We will write to you when a decision has been made.

We will only accept one application per household.
One award will be given based on the applicant with the highest need.

All of the information that you give us will be treated as strictly confidential.

Before you fill in this form please read our leaflet:
'Allocations Policy – A Housing Functional Assessment'.
http://www.moray.gov.uk/downloads/file43915.pdf

Direction for electronic use

This form has been setup for electronic use.

Please open the PDF file in Adobe Acrobat Reader DC.

You can download the software for free from the Adobe website:
https://get.adobe.com/uk/reader/

Fill out the form and **save** the file.

You can now attach the saved PDF to an email and return it to:
housing.needs@moray.gov.uk

Applicant details

1. Your details

Title
(Mr/Miss/Mrs/Ms etc)

Name

Date of birth

2. Your contact details

What address are you currently living at?

Postcode

How long have you lived at this address?

Email address

Mobile number

Phone number

3. Please tell us your correspondence address, if it is different from above

Address (for mail only)

Postcode

About the diagnosis

4. Please tell us who this assessment is for and about the diagnosis.

Tell us how long you/they have had the diagnosis, how severe it is and if you/they have been told if the condition(s) will get better, get worse or stay the same.

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

Name	Date of Birth
Describe the diagnosis	Date of diagnosis
	Will the diagnosis: get better get worse stay the same

If you need more space, please use **page 22** of this form

5. Please tell us about the treatment/medication that you/they receive.

6. Please tell us how the condition you/they have been diagnosed with is affected by your/their current home.

Please tell us why you think rehousing will improve your/their ability to carry out essential day to day activities.

7. If you/they have been diagnosed with a mental health condition or illness, please tell us how this is affected by your/their current home.

Have you/they been in hospital under mental health legislation: Yes No

If you/they have been diagnosed with a mental health condition or illness, please tell us how rehousing will improve your/their current level of difficulty.

If you/they have a Learning Disability please tell us how this is affected by your/their current home. (Please include a copy of your Self Directed Support Plan, Risk Assessment and Financial Assessment Forms, if available).

8. Do you/they have functional impairments due to any of the following: (Please tick each one that applies and give any additional comments)

Disability Yes No	If yes, are you/they registered disabled? Yes No Comments
Sensory impairment Please tick all that apply: Hearing Speech Visual problems	If yes, are you/they registered blind or partially sighted? Yes No Comments
Drug addiction Yes No	Comments
Alcohol addiction Yes No	Comments
Learning disability Yes No	Comments
Acquired brain injury Yes No	Comments
Other Yes No	Please give details
Have you/they been admitted to hospital within the last 12 months? Yes No	Please tell us the name of the hospital, the date and reason for admission

9. If you/they are currently receiving support services, please tell us:

Housing Support Name Phone number Address	How often do you/they see them? Date last seen
Community Psychiatric Nurse/Community Mental Health Team Name Phone number Address	How often do you/they see them? Date last seen
District Nurse Name Phone number Address	How often do you/they see them? Date last seen
Health Visitor Name Phone number Address	How often do you/they see them? Date last seen
Physio/Occupational Therapist Name Phone number Address	How often do you/they see them? Date last seen

Social Worker

Name

Phone number

Address

How often do you/they see them?

Date last seen

Home Care Worker

Name

Phone number

Address

How often do you/they see them?

Date last seen

Learning Disability Team

Name

Phone number

Address

How often do you/they see them?

Date last seen

Psychiatrist

Name

Phone number

Address

How often do you/they see them?

Date last seen

Psychologist

Name

Phone number

Address

How often do you/they see them?

Date last seen

Welfare Officer

Name

Phone number

Address

How often do you/they see them?

Date last seen

Relative/carer

Name

Phone number

Address

How often do you/they see them?

Date last seen

Other

Name

Phone number

Address

How often do you/they see them?

Date last seen

Do you/they have a care plan? Yes No
If yes, please provide a copy

Care Plan Coordinator's name

Care Plan Coordinator's address:

10. Do you/they have...

Difficulty getting on or off the toilet? Yes No	If yes, please tell us about the difficulty and any equipment used
A bath which you/they have difficulty getting in or out of? Yes No	If yes, please tell us about the difficulty and any equipment used
An over-bath shower, which you/they have difficulty getting in or out? Yes No	If yes, please tell us about the difficulty and any equipment used
A shower cubicle or level access shower, which you/ they have difficulty getting in or out? Yes No	If yes, please tell us about the difficulty and any equipment used

11. Please tell us if you/they need help to get around

Do you need to use any of the following: Please tick all that apply. a wheelchair indoors a wheelchair outdoors a wheelchair occasionally a wheelchair at all times any other mobility equipment Does your/their current home have room to store mobility equipment? Yes No	Comments

12. Please tell us if you/they have difficulties walking?

no walking difficulty
slight walking difficulty
it is difficult to walk
cannot walk

Please tell us how far can you/they walk at your own pace on level ground?

Comments

13. Have you/they fallen in the past 12 months?

Yes No,

If yes, please tell us:

Date of the most recent fall?

Where did you fall?

Outside Inside

Why did you fall?

Trip
Slip
Rushing
Loss of balance
Loss of attention
Other

Were you injured as a result of the fall?

Yes No

Details

If you fall, phone:

In an emergency and you are injured **999**

Out of Hours **111**

14. Do you/they receive any of the following allowances?

Personal Independent Payment (PIP) – daily living	Yes (Standard)	yes (Enhanced)	No
Personal Independent Payment (PIP) – mobility living	Yes (Standard)	yes (Enhanced)	No
Adult Disability Payment – daily living	Yes (Standard)	yes (Enhanced)	No
Adult Disability Payment – mobility living	Yes (Standard)	yes (Enhanced)	No
Child Disability Payment – daily living	Yes (Standard)	yes (Enhanced)	No
Child Disability Payment – mobility living	Yes (Standard)	yes (Enhanced)	No
Disability Living Allowance (DLA) – care component (Higher)		Yes	No
Disability Living Allowance (DLA) – mobility component (Higher)		Yes	No

15. Please tell us...

Are you/they a car owner?	Yes	No
Do you/they or a member of the household have access to a vehicle?	Yes	No
Do you/they or a member of the household have a current Blue Badge?	Yes	No

16. Do you/they have any difficulties walking up and/ or down stairs?

No difficulty with stairs Slight difficulty with stairs Stairs are difficult Cannot use stairs On an average day, how many stairs can you/they climb?	Details

About your/their current home

17. Details of your/their current home:

Please tick the box that best describes your/ their current circumstances:	Details
A Moray Council tenant	
A housing association tenant (please tell us which one in the 'Details')	
A tenant of another local authority	
A private tenant	
Living in a property I/they own	
Staying with parents	
Staying with relatives or friends	
A lodger	
In a caravan	
In hospital	
A member of the armed forces	
A tied or service tenancy	
In prison	
No fixed abode	
Other (please give details in the 'Details')	

18. Is your/their home a...

house	**If you/they live in a house or a maisonette:**
bungalow	How many bedrooms are on the ground floor?
maisonette	
ground floor flat	How many ground floor bedrooms are available for your/their household's use?
first floor flat	
second floor flat	

19. About the bedrooms in your/their current home?

How many bedrooms are there in your/their home?	Of these, how many bedrooms does your/their household use? (Household means you and the people who will be moving with you)

20. Is there a toilet?

upstairs	Yes	No	downstairs	Yes	No

21. Is there a bathroom?

upstairs	Yes	No	downstairs	Yes	No

22. How many steps are there?

outside of the property?	inside of the property?

Once inside the property are there any steps (apart from the staircase) leading up or down to the:

Toilet (how many steps)	Kitchen (how many steps)	Other (how many steps)

23. Is your/their home...

on or up a hill?	Yes	No	all on one level?	Yes	No

24. Please describe the heating in your/their home

Electric	Oil
Solid fuel	Air source heating
Gas	

Do you have an open gas flue? Yes No

25. Does your current heating system affect your health?

Yes No	If yes, please tell us how

26. Does your/their current home have any of the following facilities?

	Details
A bath only	
A bath with over bath shower	
A level access shower/wet room	
A stair lift	
Hand rails	
A garage	
A ceiling track/mobile hoist	
A ramp	
A communal lift	
A disabled parking bay	
Other, please give details	

27. Do you/they use other specialist clinical equipment?

e.g. mobile hoist, oxygen bottles, dialysis equipment etc

Yes No Does the current home have room to store the equipment? Yes No	Details

28. Approximately, how far (in miles) are you/they from your nearest:

Shops/Post Office	Bus stop

29. Do you/they need to be near support services?

Hospital Yes No Doctor/Surgery Yes No	Other support services – please give details

30. Due to a health condition, are relatives currently giving clinical care or essential support with daily living tasks to you/ a member of your household within your current home?

Yes No	Relative's name
	Relationship

Relative's address

Postcode

Phone number

What essential support is being provided?

How often is support provided? More than once per week Once per day More than once per day	On average, how many hours per visit?

31. If your/their relatives are not able to provide essential support to help with your/their clinical condition because of where you/they live, please tell us:

Relative's name

Relationship

Relative's address

Postcode

Phone number

How is the need for support currently being managed?

Do/would they use **public** transport to enable them to provide support? Yes No

Do/would they use **private** transport to enable them to provide support? Yes No

Can we contact this person to discuss this application? Yes No

32. Do you/they need a property with any of the following due to your/their clinical condition/ disability?

Over bath shower	Yes	No
Level access shower	Yes	No
Accommodation on the ground floor	Yes	No
Accommodation with a stair lift	Yes	No
Level access entry	Yes	No
Wheelchair accessible accommodation	Yes	No
Fully wheelchair adapted property	Yes	No
Partially adapted kitchen	Yes	No
Fully adapted kitchen	Yes	No
Sheltered accommodation	Yes	No

If you have been diagnosed with a mental health condition or illness, does this result in any type of accommodation being unsuitable?

Yes No

If yes, please tell us why?

Answering yes to the above questions does not guarantee that the facilities will be provided in future accommodation.

33. Is there a clinical need for you/them to have a separate bedroom?

Yes No	Name of the person needing a separate bedroom
Are they currently sharing a bedroom? Yes No	Who are they currently sharing with?
Please tell us the reason that a separate bedroom is needed?	

You must fill in questions (A – Doctor) & (B – Specialist/Consultant if applicable). This information is important to help us to process the functional assessment application.

A – Doctor

Name of doctor
Address of doctor Postcode
Phone number

B – Specialist/Consultant

Name of specialist/consultant
Address of specialist/consultant Postcode
Phone number

Please use this space to tell us any additional information which supports your need to move to alternative accommodation

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Declaration and authority to seek information

- I/we confirm that the details I/we have given are to the best of my knowledge true.
- I/we confirm my/our agreement for you to access health details from my/our doctor or other health care professional in connection with my/our application.
- I/we will notify you of any change in the details given on the application form.
- I/we agree that you can make any necessary enquiries in line with the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). This may include sharing information with other council departments and partners.
- I/we authorise you to make any referrals necessary in connection with my/our application. (This might include referrals to other services such as Occupational Therapy). I/we agree to any visits that may be needed to further assess my/our situation.

Signed (applicant)	Date
Signed (other adult members of the household aged 16 or over) that are included in question 4	Date

If you have filled in this form for the applicant please fill in the section below.

Signed on behalf of applicant	Date

Relationship to applicant

Please tell us why the applicant is unable to fill in the form

Please return this form to:

Housing and Property
Moray Council
PO BOX 6760
Elgin
IV30 9BX

0300 123 4566

housingneeds@moray.gov.uk

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