

Social housing health assessment form

IMPORTANT INFORMATION

When you make an appointment with your health professional, please let the receptionist know that you will need this document completed. Please check what the appointment might cost you.

This form must be completed by one of the following (currently involved in your treatment):

- occupational therapist
- aged care assessment officer
- general practitioner, treating doctor, specialist
- community health nurse
- clinical psychologist
- psychiatrist
- mental health social worker.

Please remember to sign the final page of this form.

You must return the completed form to Housing Connect. The information will help Housing Connect better understand what type of home you need.

If you have any questions, please talk to Housing Connect before completing this form.

Part A: About the client

CONFIDENTIAL

Part A.1 Health assessment for:

Name: _____

Date of birth: _____ Phone: _____

Address: _____

OFFICE USE ONLY

Application ID: _____

Part A.2 Relationship to main applicant

Please tick ✓ as relevant

- Self Partner or spouse Dependent child
 Independent related adult Other adult household member

Part A.3 About carers (if applicable)

Please tick ✓ as relevant

- I am a carer Are you a Related carer Non-related carer
Do you receive payment for your caring role? Yes No

Please provide payment details (eg carer payment, NDIS or other payment type):

- I have a carer

Please give details (organisation/person, live-in/hours of support, other relevant information):

Part A.4 About support (if applicable)

Please tick ✓ as relevant

- I have a support worker or agency (please provide name and contact details)
 I require a support worker or agency

Please provide details:

Information for treating health professional

Homes Tasmania works in partnership with community organisations to provide access to adequate, affordable and appropriate housing for people on low incomes.

Your assistance is requested to provide information about any physical health, mental health and/or mobility conditions of the applicant or a household member.

This information will be used by Housing Connect to help determine their housing needs.

An updated Health Assessment Form is only required when there has been a significant change in a person's health condition. This includes if a condition changes from non-permanent to permanent, or when the progression of a condition changes housing requirements.

Part B: Treating health professional's report

Does the client have any of the below physical, mental or other health conditions that are impacted or aggravated by their current living conditions?

- **Part B.1 and/or Part B.2 MUST be completed.**
- **Part B.6 MUST be completed.**

Part B.1 Health conditions

Please tick ✓ as relevant

- | | |
|--|--|
| <input type="checkbox"/> Acquired brain injury | <input type="checkbox"/> Muscular/skeletal condition |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Neuromotor impairment |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Paraplegia/quadruplegia |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Respiratory-related condition |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sensory (hearing/sight) |
| <input type="checkbox"/> Diabetes-related physical health | <input type="checkbox"/> Severe arthritis |
| <input type="checkbox"/> Multiple sclerosis | |
| <input type="checkbox"/> Other condition – please provide details: | |
-
-
-

Part B.2 Mental health conditions

Please tick ✓ as relevant

- | | |
|---|--|
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Clinical depression | <input type="checkbox"/> Substance-related disorder |
| <input type="checkbox"/> Personality disorder | <input type="checkbox"/> Other condition – please provide details: |
-
-

Part B.3 Housing requirements – amenities

Please tick ✓ as relevant

Separating ESSENTIAL and DESIRABLE housing requirements increases the likelihood of finding a property match. Please note that while every effort will be made to locate a property with all desirable requirements, this cannot be guaranteed.

What is ESSENTIAL about the property amenity (*internal and external*)?

- | | |
|--|---|
| <input type="checkbox"/> Walk-in shower | <input type="checkbox"/> Fully modified property |
| <input type="checkbox"/> Roll-in shower | <input type="checkbox"/> Disability parking |
| <input type="checkbox"/> A bath | <input type="checkbox"/> Level entry |
| <input type="checkbox"/> No wood heating (electric/gas only) | <input type="checkbox"/> No internal stairs |
| <input type="checkbox"/> Front/rear ramps | <input type="checkbox"/> Electric wheelchair access |
| <input type="checkbox"/> Other – please provide details: | |
-
-

What is DESIRABLE (but not essential) about the property amenity?

- | | |
|--|---|
| <input type="checkbox"/> Walk-in shower | <input type="checkbox"/> Fully modified property |
| <input type="checkbox"/> Roll-in shower | <input type="checkbox"/> Disability parking |
| <input type="checkbox"/> A bath | <input type="checkbox"/> Level entry |
| <input type="checkbox"/> No wood heating (electric/gas only) | <input type="checkbox"/> No internal stairs |
| <input type="checkbox"/> Front/rear ramps | <input type="checkbox"/> Electric wheelchair access |
| <input type="checkbox"/> Other – please provide details: | |
-
-

Part B.4 Housing requirements – additional bedrooms

Please tick ✓ as relevant

Note: this question relates to increasing the person's current bedroom allocation.

Is an additional separate bedroom required, due to health reasons, relating to:

- Medical equipment
 - Live-in carer (for overnight support from a person not listed on the application)
 - Other household member/s need own room (household member listed on the application)
 - Children cannot share due to disability
 - Other reason – please specify:
-
-

Part B.5 Location requirements

Please tick ✓ as relevant

What is ESSENTIAL about where the person lives?

- Close to public transport
 - Close to community health services
 - Close to hospital services
 - Environmental factors – please specify:
 - Unit complex
 - Standalone house (not a flat or unit)
 - Close to general services (banks, shops)
-

- Other ESSENTIAL location requirements – please specify:
-
-

What is DESIRABLE (but NOT essential) about where the person lives?

- Close to public transport
 - Close to community health services
 - Close to hospital services
 - Environmental factors – please specify:
 - Unit complex
 - Stand-alone house (not a flat or unit)
 - Close to general services (banks, shops)
-

- Other DESIRABLE location requirements – please specify:
-
-

Part B.6 Impact

What health condition is most affected by the person's current accommodation arrangements?

Health condition: _____

How long is this condition likely to last? *Please tick ✓ only one box*

- | | |
|---|---|
| <input type="checkbox"/> Short (up to 6 months) | <input type="checkbox"/> Medium (6 months to 2 years) |
| <input type="checkbox"/> Long (2 years or more) | <input type="checkbox"/> Permanent |

What is the severity of this condition? *Please tick ✓ only one box*

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Low | Has difficulty but doesn't need help/supervision or doesn't have difficulty but uses aids/equipment |
| <input type="checkbox"/> Medium | Has difficulty and occasionally needs help/supervision |
| <input type="checkbox"/> High | Always or frequently needs help/supervision |

Please note: The health professional completing this form must be currently involved in the treatment of the listed person and details must be provided below.

Part B.7 Completing health professional details

Full name: _____

Please tick ✓ one below

- | | |
|--|---|
| <input type="checkbox"/> General practitioner | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Specialist physician | <input type="checkbox"/> Community health nurse |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Aged care assessment officer |
| <input type="checkbox"/> Clinical psychologist | <input type="checkbox"/> Mental health social worker |

Address: _____

Suburb: _____ Postcode: _____ Phone: _____

Email: _____

Signature and/or stamp of health professional

Date

Part C: Client declaration and permission

I give permission for the above health professional to release this information to Housing Connect.

I understand that the information in this document will be used to help Housing Connect assess my application for social housing.

I agree that the information in this form is true and correct at the time it was completed.

Signature of applicant or guardian

Date

Please make sure that Part B.1 and/or B.2 have been completed.

Please make sure Part B.6 has been completed.

Please return this completed form to your nearest Housing Connect office:

North and North-West	South
In person or by post: 118 Elizabeth Street, Launceston 31 King Street, Devonport 51 Wilmot Street, Burnie 43 Smith Street, Smithton (<i>Wyndarra Centre</i>)	In person: Level 3, 181 Collins St, Hobart By post: GPO Box 1679, Hobart, TAS, 7001
Email: North: hadmin@anglicare-tas.org.au NW: hcnwadmin@anglicare-tas.org.au	Email: housing@colony47.com.au