

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

Full name of applicant

Applicant's address

  
  

Postcode

Date of birth

Bridge Housing Client Number (if available)

### Authorisation of applicant with medical condition

I give permission for medical details affecting my need for housing to be released to Bridge Housing and, if necessary, for my doctor/health care professional to discuss these details on my behalf with an officer of Bridge Housing, I have read and understand the following notice.

#### Notice

This is a notice under the *Privacy and Personal Information Protection Act 1998* (PIIP Act) and the *Health Records and Information Privacy Act 2002* (HRIP Act), which govern the collection, security, use and disclosure of personal information and health information respectively. Bridge Housing Limited collects personal information (including health information) in order to provide services to you. The supply of the information by you is voluntary. If you cannot or do not wish to provide the information, Bridge Housing may be unable to process your application. The intended recipients of your information include those involved in the administration of your housing application or tenancy or any others who may have an interest in considering your application or tenancy including where relevant the Aboriginal Housing Office, the Community Housing Division (of Housing NSW) or a community housing organisation, or Housing Appeals Committee 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. Bridge Housing 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 PIIP Act, HRIP Act, or by another Act or law. You have a right of access to, and correction of, your personal information held by Bridge Housing to ensure it is accurate and not misleading. If you have any questions about privacy and your personal information, please contact the Bridge Housing office.

Name (please print)

Signature

  

Date

## 2. To the Health Care Professional

The above client/patient has presented to Bridge Housing requesting Housing Assistance or Housing Transfer. Bridge Housing 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 need 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 the Bridge Housing?**

- 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?**

- Yes  **Go to next question**
- No  **Give details**


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

No  [Go to next question](#)

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  [Go to next question](#)

Yes  [Explain how](#)


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

No  [Go to next question](#)

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?

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18. Is there a second suitable location?

No  [Go to next question](#)

Yes  [Give details](#)


19. Is the patient/client's mobility restricted?

No  [Go to 24](#)

Yes  [Go to the next question](#)

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

No  [Go to next question](#)

Yes  [Give details](#)


21. Does the client/patient require modified housing?

No  [Go to next question](#)

Yes  [Give details](#)


22. Can the client/patient manage steps?

No  [Go to next question](#)

Yes  [How many?](#)

0  1-2  3-5  6 or more

23. Are there any other mobility restrictions?

No  [Go to next question](#)

Yes  [Explain how these effect their housing](#)


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

No  **Go to 29**

Yes  **Go to next question**

25. Has an independent living skills assessment been done?

No  **Go to next question**

Yes  *Please attach the independent living skills assessment*

26. Does the client/patient need a carer?

No  **Go to 28**

Yes  **Go to next question**

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

No  *How long before needed?*

Yes  *Is the carer:*  Part time  
 Full time  
 On a needs basis

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

28. Does the client/patient need regular support?

No  **Go to next question**

Yes  *List support*


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

No  **Go to 33**

Yes  **Go to next question**

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

No  **Go to next question**

Yes  *Give details*


31. Is the condition supported by other health professionals?

No  **Go to next question**

Yes  *Who provides this support?*

*Tick All That Apply*

Mental health workers

Counsellors

Psychiatrists

Other health professional  *Give details*


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

No  **Go to next question**

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  **Go to next question**

Yes  *Give details*


35. Checklist

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

Independent living skills assessment

Occupational Therapist's report detailing modifications

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