Housing Pathways

Medical Assessment

This form is to be completed by the client's health care professional to provide information about the client's medical condition. Page 1 is to be completed by the client and the health care professional is to complete page 2 onwards. Please use BLOCK LETTERS and print in black or blue pen only. Please mark all relevant boxes with a ✗. If you need more space, please write on a blank page and attach it to this form. For information or assistance with this form, phone 1800 422 322, 24 hours a day, 7 days a week.

Client reference number

T-File number

Application reference number

Payment reference number

Name of social housing provider

Client details

Title
Mr, Mrs, Ms, Miss, Mx

Last name
or family name

First and middle name(s)

Date of Birth DD/MM/YYYY

Unit/House number

Street/Avenue

Town/Suburb

Postcode

Contact number

Email address

DCJ Privacy Notice

This notice outlines how the Department of Communities and Justice (DCJ) collects, uses, stores and discloses your personal and or health information in accordance with the *Privacy and Personal Information Protection Act 1998* (NSW) (PPIP Act) and the *Health Records and Information Privacy Act 2002* (NSW) (HRIP Act).

DCJ collects personal and or health information from time to time in connection with your application for housing services or during your tenancy for the purposes of assessing and processing your application for housing assistance and or administering your tenancy.

We may also collect information to provide you with support services, related to your tenancy or as a client of DCJ. This information may be collected from:

- you directly
- individuals who are visiting or residing at the same residential address as you
- members of the public
- Community Housing Providers
- your authorised representatives
- other third parties, for example medical practitioners
- other NSW or Commonwealth government agencies (as permitted by law).

DCJ Privacy Notice continured

This information is held by DCJ, and where relevant Community Housing Providers. The information held relates to services provided to you, including the details you provide in this document and information in other documentation completed or provided by or on your behalf, and it also relates to information you provide to our staff or Community Housing Providers (for example, during your public housing tenancy sign-up process).

DCJ may also use your information for data analytics, data matching and data integration on DCJ's Federated Analytics Platform (FAP). In addition to the use of your information on the FAP, this information will also support policymaking, program and service planning, delivery of targeted services for clients, program evaluation, monitoring and reporting, research and resource planning. We may also use your information within DCJ to plan, coordinate and improve the way we provide services. This includes use of the information by companies contracted by DCJ, for example, for the purposes of determining client satisfaction and related long-term service enhancement.

Intended recipients of your personal and or health information include those involved in the above activities, as well as any others who may have a lawful interest in considering your application or tenancy, including where relevant the:

- DCJ
- Aboriginal Housing Office
- Community Housing Providers
- Housing Appeals Committee
- NSW Land and Housing Corporation.

DCJ may also disclose your personal and or health information where required or permitted by law, for example:

- for purposes relating to child protection, health reasons, protection of public revenue, and or law enforcement
- to relevant statutory bodies
- to other co-tenants, authorised occupants and or visitors of the subject residential address.

The supply of your personal and or health information in this form is voluntary; however, if you do not supply us with the information we request, we may not be able to process your application, provide services to you or other individuals affected by your tenancy, or provide other forms of assistance.

You have a right of access to and correction of your personal and health information held by DCJ in accordance with the PPIP Act and the HRIP Act. Further information about your privacy rights are available on the DCJ website at https://www.dcj.nsw.gov.au/privacy-notice.

Declaration

- I have read and understand the above notice.
- To the best of my knowledge, the information provided in this application is correct.
- I understand there are penalties for giving false or misleading information.
- I consent to the personal and medical information I have provided in this application, and which is stored in DCJ' records, being shared with other social housing providers so that appropriate services can be identified and delivered and, if necessary, for my doctor or health care professional to discuss these details on my behalf with the social housing provider.

Client to sign	Name	
	Signature	✕
	Date	DD/MM/YYYY

To the health care professional

The client has presented to the social housing provider requesting housing assistance. Social housing providers are committed to allocating suitable housing and creating sustainable tenancies. When completing this form it is important to take into account that information you provide will be most helpful to the client if it reflects your professional opinion. The information you provide will assist in accurately assessing the client's housing need, including particular housing features, such as type or location.

If a client requires a property to be modified to suit their medical or disability needs, it is recommended that an occupational therapist provides a Housing Needs Assessment that clearly outlines the home modifications required.

To assist in this process the following information is required.

Details of health care professional completing this form

Title
Mr, Mrs, Ms, Miss, Mx, Dr

Last name or family name

Organisation Name

Unit/House number

Street/Avenue

Town/Suburb

Postcode

Contact number

Email

Provider number

1. Please describe the professional service you provide to the client.

☐ General practitioner ☐ Specialist

☐ Other ☐ Allied health worker

give details

2. Please describe your field of expertise.

3. How long has the client been one of your patients?

☐ One consultation only ☐ Weeks

☐ Months ☐ Years

4. Please provide details of the client's medical condition and the affects it has on both their housing needs and their ability to access and sustain housing.

Name of medical condition(s)

Description of condition(s)

How the condition(s) affects the client's housing needs

Frequency of visits to the practitioner

Overall impact of the condition(s) on the client's wellbeing (please tick)

☐ Minor ☐ Moderate ☐ Severe

5. What is the likely duration of the condition(s)? (please tick)

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

6. Do any of the above medical conditions restrict the client from accessing the required health service by walking or taking public transport?

☐ Yes give details ☐ No → Go to 7.

7. Is the client's current accommodation exacerbating their medical condition(s)? (e.g. lack of room for specialised medical equipment, property not suitably accessible)

☐ Yes give details ☐ No → Go to 8.

8. Is the client's mobility restricted?

☐ Yes give details ☐ No → Go to 9.

9. Can the client manage steps/stairs?

☐ Yes - how many? ☐ No → Go to 10.

☐ 1-2 ☐ 3-5 ☐ 6 or more

10. Does the client need accommodation that is modified? (e.g. hobless shower, 1/4 turn taps, wheelchair access)

☐ Yes → Go to 11. ☐ No → Go to 12.

11. Is a low or high level of modification required?

☐ **Low:** Mainly standard, necessary, practical aids unlikely to require extensive work e.g. lever taps, grab rails, accessible door handles, painting of door frames or steps to improve visibility.

☐ **High:** Where high level modifications are required, provide an occupational therapist's Housing Needs Assessment that clearly outlines the home modifications required.

Give details

12. Does the client's condition(s) affect their ability to look for suitable private rental accommodation?

☐ Yes ☐ No → Go to 13.

give details

13. Does the client have extra expenses because of their medical condition(s)?

☐ Yes ☐ No → Go to 14.

list the expenses incurred on a regular basis which may cause financial hardship to the client

14. Has anyone in the household reached, or is likely to reach the annual Medicare Safety Net threshold by 31 December of this year? (See www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets/what-are-thresholds).

☐ Yes ☐ No → Go to 15.

give details

15. Has anyone in the household reached, or is likely to reach the annual Pharmaceutical Benefits Scheme Safety Net threshold by 31 December of this year? (See www.servicesaustralia.gov.au/individuals/services/medicare/pharmaceutical-benefits-scheme/when-you-spend-lot-pbs-medicines).

☐ Yes ☐ No → Go to 16.

give details

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

☐ Yes — what location is required?

☐ No → Go to 17.

17. Has an independent living skills assessment been done?

☐ Yes — attach the independent living skills assessment

☐ No → Go to 18.

18. Is the client able to live independently without support?

☐ Yes → Go to 24.

☐ No - tick required support

☐ Personal care
☐ Cooking
☐ Shopping
☐ Cleaning
☐ Financial management
☐ Identifying unsafe situations
☐ Other give details
☐ Transport

19. Does the client currently have support for these functions?

☐ Yes → Go to 20.

☐ No → Go to 21.

20. Who provides this support?

☐ NDIS
☐ Carer
☐ HASI
☐ Other

Name of support person/provider

21. Does the client currently have a carer?

☐ Yes

☐ No → Go to 24.

22. Is the carer (please tick)

☐ Part time
☐ Full time
☐ On a needs basis

23. Does the carer live with the client?

☐ Yes

☐ No → Go to 24.

24. Do psychological issues affect the client's ability to cope?

☐ Yes

☐ No → Go to 28.

25. Does the condition(s) require medication for the client to live independently?

☐ Yes
give details

☐ No → Go to 26.

26. Is the client's condition(s) supported by other health professionals?

☐ Yes - tick all that apply

☐ No → Go to 27.

☐ Mental health workers

☐ Counsellors

☐ Psychiatrists

☐ Other health professionals
give details

27. Does the client have a particular dwelling requirement as a result of the condition(s)?

☐ Yes
give details

☐ No → Go to 28.

28. Would you like to add further comments to support the client's needs?

☐ Yes
give details

☐ No → Go to checklist.

Checklist

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

☐ Independent living skills assessment

☐ Occupational therapist's Housing Needs Assessment detailing required modifications

☐ Other documentation
give details

Practitioner's name

Signature ×

Date DD/MM/YYYY

Thank you for taking time to complete this form