 

**LONDON BOROUGH OF HAVERING HOUSING SERVICES**

**Extra Care Questionnaire – (CONFIDENTIAL)**

**Please write clearly and answer all the questions that apply to you as fully as possible.**

**If you have difficulty completing this form, please contact the Housing Needs Team on
01708 434130 or** **email:** housingneeds@havering.gov.uk

**PLEASE COMPLETE IN BLOCK CAPITALS and use BLACK ink**

**Please return the completed form to: Housing Choice and Application Team, Town Hall, Main Road, RM1 3BB**

**You will need to provide documents to support your application, please send in a copy of birth certificate or copy of your passport.**

**If there is more than one person in the household who needs to be assessed, please complete a separate form for each person.**

# Applicant Details

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|  **ABOUT YOU** |  **ABOUT YOUR PARTNER** |
|  Title Mr [ ]  Mrs [ ]  Ms [ ]  Miss [ ]  |  Title Mr [ ]  Mrs [ ]  Ms [ ]  Miss [ ]  |
| Family Name / Surname Click or tap here to enter text. | Family Name / Surname Click or tap here to enter text. |
| First Name(s) Click or tap here to enter text. | First Name(s) Click or tap here to enter text. |
| Date of Birth Click or tap here to enter text. | Date of Birth Click or tap here to enter text. |
| Gender Click or tap here to enter text. | Gender Click or tap here to enter text. |
| First Language Click or tap here to enter text. | First Language Click or tap here to enter text. |
| Interpreter Required Yes [ ] No [ ]  | Interpreter Required Yes [ ] No [ ]  |
| National Insurance Number Click or tap here to enter text. | National Insurance Number Click or tap here to enter text. |
| **Marital Status** | **You** | **Partner** | **Date** |
| Married | [ ]  | [ ]  |  |
| Divorced | [ ]  | [ ]  |  |
| Separated | [ ]  | [ ]  |  |
| Never Married | [ ]  | [ ]  |  |
| Widow | [ ]  | [ ]  |  |
| Widower | [ ]  | [ ]  |  |

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| 1. **CONTACT DETAILS**
 |
|  | **You** | **Your Partner** |
| Home Phone Number. |  Click or tap here to enter text. |  Click or tap here to enter text. |
| Mobile Phone Number |  Click or tap here to enter text. |  Click or tap here to enter text. |
| Work Phone Number |  Click or tap here to enter text. |  Click or tap here to enter text. |
| E-Mail address |  Click or tap here to enter text. |  Click or tap here to enter text. |
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| 1. **CURRENT ADDRESS**
 |
| Click or tap here to enter text. |
|  |
|  | Post Code |
| Date you started living at this address |  |

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| 1. **DETAILS OF ALL PERSONS REQUIRING ACCOMMODATION.**

Please enter your name first, followed by all other household members you want to be re- housed as part of this application |
| Surname / Family Name | First Name | Male / Female | Date of Birth | Relationship to you (example, wife, son, daughter) | National Insurance Number |
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| 1. **DETAILS OF WHERE YOU ARE LIVING NOW -** Tick which applies to you
 |
| London Borough of Havering Council Tenant | [ ]  | Emergency hostel or refuge | [ ]  |
| Housing Association Tenancy | [ ]  | Hospital rehabilitation unit | [ ]  |
| A tenancy with another Council | [ ]  | Own your own home | [ ]  |
| Private Landlord tenant | [ ]  | Hotel or bed & breakfast | [ ]  |
| Live in private rented property let to you by Havering Council | [ ]  | Tied Accommodation | [ ]  |
| No home at all | [ ]  | Living with family or friends | [ ]  |
| Local Authority License | [ ]  | Other – please state | [ ]  |

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| 1. **ABOUT YOUR CURRENT ACCOMMODATION:** Tick which applies to you
 |
| House | [ ]  | Flat with lift | [ ]  |  Maisonette | [ ]  |
| Flat without lift | [ ]  |  No Home | [ ]  |  Bed-Sit | [ ]  |
| Flat – ground floor | [ ]  |  Bungalow | [ ]  |  Mobile Home/Caravan | [ ]  |
|  Other – Please Specify | [ ]  | Is there a lift | Yes [ ] No [ ]  |
| What is the floor level of your front door? |  | Is the staircase Internal or External  | Internal [ ]  External [ ]  |

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| 1. **CONDITION OF PROPERTY**
 |
| Do you consider your current home to be in a bad state of repair?  | Yes [ ]  |  No [ ]  |
|  If yes, please give details: Click or tap here to enter text. |

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| 1. **DO YOU HAVE CENTRAL HEATING**
 | Yes [ ] ****No [ ]  |
| Please give details of the type of heating in your accommodation. Click or tap here to enter text. |
|  If you have central heating is it Part or Full | Part [ ] ****Full [ ]  |
|  Gas [x] ****Oil Fired [ ]  Warm Air [ ]  |
|  In which room(s)? Click or tap here to enter text. |
|  If dwelling is not centrally heated, please specify type of heating and in which rooms:- |
|  Click or tap here to enter text. |

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| 1. **HOW MANY ROOMS ARE IN THE PROPERTY**? (Write in the number of each type of room)
 |
| Bedsit [x]  | Bedroom [ ]  | Living Room [x]  | Kitchen [ ]  |
|  Bedsit Shared Facilities [ ]   | Bathroom [ ]  | Dining Room [x]  | Loft Conversion [x]  |
| Separate Toilet [ ]  | Other- please [ ] specify  |   |

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| 1. **HOW ARE THE ROOMS OCCUPIED?**

 Please indicate all persons living in the property whether or not they are part of your housing application |
|  | Name | Date of Birth | Relationship |
| Bedroom 1 |  |  |  |
| Bedroom 2 |  |  |  |
| Bedroom 3 |  |  |  |
| Bedroom 4 |  |  |  |
| Bedroom 5 |  |  |  |
| Living Room |  |  |  |
| Dining Room |  |  |  |
| Loft Conversion |  |  |  |

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| 1. **PLEASE GIVE DETAILS OF YOUR PREVIOUS ADDRESSES IN THE LAST TEN YEARS, INCLUDING DATES**
 |
| Address | Tenancy Type |  From |  To |  Reason for leaving |
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| 1. **EVICTIONS**

Have you or anyone included in your application been evicted from any previous address? |
| Yes | [ ]  | No | [ ]  |
| If yes, please give details Click or tap here to enter text. |

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| 1. **HAVE YOU OR ANY PERSON INCLUDED IN THIS APPLICATION BEEN SERVED WITH AN ANTI-SOCIAL BEHAVIOUR ORDER OR SIGNED AN ACCEPTABLE BEHAVIOUR CONTRACT?**
 |
| Yes | [ ]  | No | [x]  |
| If yes, please give details Click or tap here to enter text. |

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| 1. **DETAILS OF PREVIOUS ADDRESSES WHERE YOU, YOUR HUSBAND/WIFE/PARTNER HAS LIVED IN THE LAST 10 YEARS**
 |
| Address | Tenancy Type | From | To |  Reason for leaving |
|  |  |  |  |  |
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| 1. **Occupation**
 |
|  Are you Employed | **Yes** [ ] **No** [ ]  |
|  Are you Unemployed | **Yes** [ ] **No** [ ]  |
|  Are you Retired | **Yes** [ ] **No** [ ]  |
|  Other – please specify  | **Yes** [ ] **No** [ ]  |
|  What is your current occupation? Click or tap here to enter text. |
|  Can you cope with Full Time Work  | **Yes** [ ] **No** [ ]  |
|  Have you had to change occupation Because of your medical condition/disability | **Yes** [ ] **No** [ ]  |
|  Are you only capable of part-time work because of your medical condition/disability? | **Yes** [ ] **No** [ ]  |

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| 1. **YOUR INCOME AND SAVINGS AND PROPERTY INTERESTS**

Please give details of your household’s total **WEEKLY** income |
| Weekly Income | You **£** | Partner **£** | Others **£** |
| Take home salary / wages **after** tax and national insurance |  |  |  |
| Jobseekers Allowance |  |  |  |
| Family Working Tax Credit |  |  |  |
| Income Support |  |  |  |
| Child Benefit |  |  |  |
| Housing Benefit |  |  |  |
| State Pension |  |  |  |
| Occupational Pension |  |  |  |
| Incapacity Benefit |  |  |  |
| Disability Living Allowance |  |  |  |
| Attendance Allowance |  |  |  |
| Oher Income - PLEASE SPECIFY |  |  |  |
| **WEEKLY TOTAL** | £ | £ | £ |

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| 1. **IF YOU OR ANYONE INCLUDED IN YOUR APPLICATION HAS SAVINGS.** Please give details
 |
| Name of Person | Type of SavingFor example bank account | Amount £ |
|  |  |  |
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| 1. **HAVE YOU, OR ANYONE INCLUDED IN YOUR APPLICATION, EVER OWNED OR HAD A LEGAL INTEREST IN ANY PROPERTY EITHER IN THE UNITED KINGDOM OR ANY OTHER COUNTRY?** (Including your current home)?
 |
| Yes | [x]  | No | [x]  |
| If yes, please give details: Click or tap here to enter text. |
|  | You | Partner |
| Name |  |  |
| Address of Property |  |  |

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| 1. **IMMIGRATION**

Are you or anyone included in your application aged 16 or over a citizen of a country other than the United Kingdom? |
| Yes | [x]  | No | [x]  |
| If yes, please give details and provide documentationPlease note we will be unable to process your application until you have provided documentation |
| Name | Immigration status | Nationality |
|  |  |  |
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|  | 1. **SEX OFFENDERS ACT: Have you or any person included in your application been convicted under the Sex Offenders Act 1956, 1997 or 2003 and / or been placed on the Sex Offenders Register?**
 |  |
| Yes | [x]  | No | [x]  |
| If yes, please give details: |
|  |  Person 1 | Person 2  |
| Name |  |  |
| Date of Conviction |  |  |
| Name and address of court |  |  |
| Details of Probation Officer/ and / or Police Station reporting to: |
| Name | Address |

# Health Details

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| 1. **DETAILS OF ILL HEALTH OR DISABILITY**
 |
|  **Condition**  | **How long have you had this condition?** |
| Click or tap here to enter text. |  Click or tap here to enter text. |

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| 1. **HAS YOUR PROPERTY BEEN ADAPTED?** e.g. (level access shower, ramps, hand-rails, raised toilet seat, stair lift, overhead hoists etc)
 |
|  **Adaptation** | **Location of Adaptation** |
| Click or tap here to enter text. |  Click or tap here to enter text. |

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| 1. **Please give details of any prescribed medication being used for the problems you have mentioned.**
 |
| **Name of medication** | **How often taken** |
| Click or tap here to enter text. | Click or tap here to enter text. |

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| 1. **In relation to the specific medical problems or disability you have referred to, please describe any hospital treatment that has been received.**
 |
| **Name of Hospital** | **In** **Patient** | **Out** **Patient** |  **Treatment** |  **Last Time Attended/Admitted** |
|  |  [ ]  |  [ ]  |  |  |
|  |  [ ]  |  [ ]  |  |  |
|  |  [ ]  |  [ ]  |  |  |
|  |  [ ]  |  [ ]  |  |  |

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| 1. **Mobility**
 |
|  Do you have problems with mobility? | **Yes** [ ] **No** [ ]  |
|  Do you have difficulty walking? | **Yes** [ ] **No** [ ]  |
|  If **YES** are you able to walk unaided? | **Yes** [ ] **No** [ ]  |
| Do you use a Stick/s to Walk Crutches to Walk Zimmer Frame to Walk | **Yes** [ ] **No** [ ] **Yes** [ ] **No** [ ] **Yes** [ ] **No** [ ]  |
| Can you Walk - 10 meters/yards | **Yes** [ ] **No** [ ]  |
| Can you Walk - 100 meters/yards | **Yes** [ ] **No** [ ]  |
| Can you Walk - 400 meters or ¼ mile | **Yes** [ ] **No** [ ]  |
| Can you Walk - 800 meters or ½ mile | **Yes** [ ] **No** [ ]  |
| Are you able to stand without help | **Yes** [ ] **No** [ ]  |
| Do you have difficulty climbing a flight of stairs? | **Yes** [ ] **No** [ ]  |
| Do you have difficulty in climbing one or two steps? | **Yes** [ ] **No** [ ]  |
| Do you use a wheelchair? | **Yes** [ ] **No** [ ]  |
|  If **YES** do you use the wheelchair outdoors only  | **Yes** [ ] **No** [ ]  |
| Do you use an electric scooter | **Yes** [ ] **No** [ ]  |
| If **YES** do you use it Indoors sometimes? | **Yes** [ ] **No** [ ]  |
| Indoors always? | **Yes** [ ] **No** [ ]  |
| Are you able to stand without help | **Yes** [ ] **No** [ ]  |
| Do you have problems using lifts? | **Yes** [ ] **No** [ ]  |
| If **YES** give reasons and include any treatment you have had: |
| Click or tap here to enter text. |
| Name and address of Social Services Officer who we may contact for a report |
|  Click or tap here to enter text. |
|  **NB:** To enable the medical advisor to recommend the type of property and / or floor level,  Full details are necessary. Please continue on a separate sheet if necessary. |

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| 1. **Other Difficulties**
 |
|  Do you have difficulty with your hearing? | **Yes** [ ] **No** [ ]  |
|  Do you have problems with your sight? | **Yes** [ ] **No** [ ]  |
|  Do you have problems with your speech? | **Yes** [ ] **No** [ ]  |
|  Do you suffer with incontinence? | **Yes** [ ] **No** [ ]  |
|  Do you have difficulty breathing? | **Yes** [ ] **No** [ ]  |

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| 1. **Do you use any of these services regularly?**
 |
|  Meals on Wheels | **Yes** [ ] **No** [ ]  |
|  Home Help | **Yes** [ ] **No** [ ]  |
|  Bath Attendant | **Yes** [ ] **No** [ ]  |
|  Ambulance to Out Patients  | **Yes** [ ] **No** [ ]  |

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| 1. **Can you do the following things WITHOUT help**
 |
|  Use a Bath | **Yes** [ ] **No** [ ]  |  General Housework | **Yes** [ ] **No** [ ]  |
| Use a Toilet  | **Yes** [ ] **No** [ ]  |  Wash - Self | **Yes** [ ] **No** [ ]  |
|  Cook | **Yes** [ ] **No** [ ]  |  Wash - Clothing | **Yes** [ ] **No** [ ]  |
|  Shopping | **Yes** [ ] **No** [ ]  |  Use Public Transport | **Yes** [ ] **No** [ ]  |
|  Gardening | **Yes** [ ] **No** [ ]  |  |  |
| Please specify where help is given or needed? Click or tap here to enter text. |
|  |  |  |  |  |
| 1. **Are you able to drive a car unaided**
 |  **Yes** [ ] **No** [ ]  |
| If **No** please specify how your car is adapted Click or tap here to enter text. |
|  |  |  |  |  |
| 1. **Please tell us how your health problems/disability affect your ability to live in your present housing for example, problems in getting to the toilet, bath or outside, location of steps and stairs.**
 |
| Click or tap here to enter text. |

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| 1. **ASTHMA QUESTIONNAIRE – APPLICANTS / TENANTS**
 |
|  Name and address |
|  |
|  |
|  How Long have you had asthma? |  |
|  What medication do you take? |  |
|  Do you take medication | **Regularly** [ ] **When necessary** [ ]  |
|  Do you smoke? |  **Yes** [ ] **No** [ ]  |
|  Do you use oxygen (at home)? |  **Yes** [ ] **No** [ ]  |
|  If **YES**, how often Click or tap here to enter text. |
| When was the last severe attack, needing the attention of a Doctor? |
|  Click or tap here to enter text. |
|  Date of last hospital admission? |  |
|  Number of days in hospital |  |
|  What does your peak flow measure? |  |
|  Have you had any time off work / school because of asthma? Please give details: |
|  Click or tap here to enter text. |

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| 1. **PHOBIAS – A FEAR OR AVERSION**
 |
|  Do you suffer from any phobias |  **Yes** [ ] **No** [ ]  |
|  If **YES** please give details of your phobia and how it affects you? |
|  Click or tap here to enter text. |
|  When did you first realise you had this problem? |
|  Click or tap here to enter text. |
|  What happened during the first incident? |
|  Click or tap here to enter text. |
|  Has the phobia been severe enough for you to seek help from your doctor? |  **Yes** [ ] **No** [ ]  |
|  If **YES**, when did you first inform your doctor of the problem? |
|  Click or tap here to enter text. |
|  What treatment was recommended for you? Click or tap here to enter text. |
|  What was the outcome of the treatment? Click or tap here to enter text. |
|  Are you still receiving this treatment?  |  **Yes** [ ] **No** [ ]  |
|  If you have a phobia of heights / lifts, which of the following applies to you? |
|  Able to use a lift  |  **Yes** [ ] **No** [ ]  |
|  Completely unable to use a lift  |  **Yes** [ ] **No** [ ]  |
|  Find using lifts very difficult and avoid the situation wherever possible |  **Yes** [ ] **No** [ ]  |
|  Able to be at height |  **Yes** [ ] **No** [ ]  |
|  Completely unable to be at height |  **Yes** [ ] **No** [ ]  |
|  Find being at height difficult and avoid the situation wherever possible |  **Yes** [ ] **No** [ ]  |
|  What was the outcome of treatment? |
|  How do you manage in buildings with lifts e.g. hospitals, shopping centres? |
| Click or tap here to enter text. |
|  Are you able to climb a flight of stairs or do you require accommodation all on one level? |
| Click or tap here to enter text. |

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| 1. **Permission to contact your Doctor / Hospital Consultant or any other external and internal Agencies, including Social Services for further information or to make any relevant referral.**
 |
| I am willing for my family doctor, hospital consultant or any other agencies to be consulted if necessary about the conditions stated on this Medical Circumstances Form. (If persons are less than 16 years of age a parent or guardian should sign on behalf of this person). |
| GP Name: Click or tap here to enter text. |
| Address: Click or tap here to enter text. |
| Consultants name: Click or tap here to enter text. |
| Address: Click or tap here to enter text. |
| Hospital name: Click or tap here to enter text. |
| Hospital record number (if known) Click or tap here to enter text. |
| Social Worker’s Name: Click or tap here to enter text.Office addressTelephone Number |
|  Signed:  | Date: |

# Declaration

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|  **EQUAL OPPORTUNITIES IN HOUSING**The London Borough of Havering’s policy is to treat everyone equally, whatever their age, sex, race, colour, disability, mental status or sexual orientation. To help operate this policy, we would like you to tell us what you consider your ETHNIC GROUP to be. This information will be treated as **STRICTLY CONFIDENTIAL.** Your ethnicity will not be taken into account when making you an offer. We only need it to monitor that we are acting in a fair way. We would appreciate your help with this. |
| Ethnic Origin | Applicant | Partner | Please Specify |
| 1. White British
 | [ ]  | [ ]  |  |
| 1. White Irish
 | [ ]  | [ ]  |  |
| 1. White – Any other White Background
 | [ ]  | [ ]  | Please Specify |
| 1. Mixed: White and Black African
 | [ ]  | [ ]  |  |
| 1. Mixed: White and Black Caribbean
 | [ ]  | [ ]  |  |
| 1. Mixed: White and Asian
 | [ ]  | [ ]  |  |
| 1. Mixed: Any other mixed background
 | [ ]  | [ ]  | Please Specify |
| 1. Asian or Asian British: Indian
 | [ ]  | [ ]  |  |
| 1. Asian or Asian British: Pakistani
 | [ ]  | [ ]  |  |
| 1. Asian or Asian British: Bangladeshi
 | [ ]  | [ ]  |  |
| 1. Any other Asian Background
 | [ ]  | [ ]  | Please Specify |
| 1. Black or British-Caribbean
 | [ ]  | [ ]  |  |
| 1. Black or British-African
 | [ ]  | [ ]  |  |
| 1. Black or British-Other
 | [ ]  | [ ]  | Please Specify |
| 1. Chinese or British-Chinese
 | [ ]  | [ ]  |  |
| 1. Other or Other British
 | [ ]  | [ ]  | Please Specify |
| 1. Not stated
 | [ ]  | [ ]  | Please Specify |

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| **DECLARATION**This Authority is under a duty to protect the public funds it administers and to this end may use the information you have provided on this form within this Authority for the prevention and detection of fraud. We may also share this information with Housing Benefits and Housing Associations to whom you have been nominated and other bodies administering public funds, solely for these purposes.**The information I/we have given is a true, correct and complete record of my/our current housing circumstances and I/we will tell the London Borough of Havering if any of my/our circumstances change.****I/we understand that the London Borough of Havering will check the information provided. Any misrepresentation or false statement made by me/us or any person(s) on my/our behalf, will lead to exclusion from the Waiting List and the Council may prosecute me/us. If, I/ we have been re-housed, the Council may take legal action to recover the property.****I/we agree that the London Borough of Havering may process and hold this personal information in accordance with the requirements of the Data Protection Act 1998.****I/ we agree to give the London Borough of Havering’s Housing Services authority to contact any organisation it needs to for information that it reasonably requires in connection with this application and give my/our permission for it to be released.** |
| Your Signature | Date: |
| Partner’s Signature | Date: |