HMD-Form 1

Disability and/or Medical Information Form

October 2023

About this form

This form must be completed if applying for Social Housing Support due to a disability or on medical grounds. This form should also be used when applying for a transfer based on disability or on medical grounds from your existing social housing tenancy.

- The information you provide will be used by the local authority to help assess your housing need or that of a household member for Social Housing Supports. It will also assist the local authority **to consider if you have any specific housing requirements arising from your disability or medical condition.**

- The local authority makes offers of accommodation in line with the order of priority as set out in their Allocation Scheme. The local authority will make reasonable efforts to ensure the offer is suitable to meet the applicant's housing need, including any specific accommodation requirements the local authority deem are necessary. Offers of accommodation are dependent on the availability of suitable properties.

- Two Healthcare Professionals, who are registered to practice in Ireland, will be required to fill out parts of this form for you. A Healthcare Professional includes registered Medical, Nursing, Health or Social Care Professionals. These include a Consultant, General Practitioner (GP), Mental Health Nurse, Public Health Nurse, Nurse, Occupational Therapist, Social Worker, or any other registered healthcare professional deemed appropriate by the local authority for the purpose of providing the information required in the form.

- For clarity, the form should be completed by two different Healthcare Professionals, for example a Consultant and a GP; a GP and a Public Health Nurse; a Consultant and a Social Worker and so on. This is to ensure that the form gives a broad perspective and as much relevant information as possible about your circumstances and housing needs.

How to fill this form

Please read the following information carefully:

There are 3 separate parts to the HMD-Form 1. All 3 parts must be completed in full and submitted together to your local authority.

Part 2 and Part 3 are not contained in this document. Please ensure you download or get a hard copy of Part 2 and 3 from your local authority.

Part 1 is this document and must be completed by you.

Part 2 must be completed by your first chosen Healthcare Professional (A).

Part 3 must be completed by your second chosen Healthcare Professional (B).

- Part 1 must be completed in full by the applicant for Social Housing Support. If you include details of members of your household who are over the age of 18, they must provide their consent for you to share their disability/medical information with the local authority.

- Part 2 and Part 3 must be completed by Healthcare Professionals who work with the disabled person or person with a medical condition. Please note that two separate Healthcare Professionals are required; one to fill out Part 2 - Healthcare Professional (A) and the second to fill out Part 3 - Healthcare Professional (B).

- All three Parts of the form must be submitted together to your local authority. Incomplete forms or those missing Parts 1, 2 or 3 will not be accepted and will be returned to the applicant.

Other information

If you require clarity on whether the Healthcare Professionals you intend to seek assistance from to complete this form are suitable, please contact your local authority.

The local authority reserves the right to request back up information from the applicant to support their application. Such information includes occupational therapist reports, psychiatrist reports, or other such relevant evidence to facilitate the local authority to determine the appropriate form of Social Housing Support and/or specific accommodation requirements of the applicant.

Part 1 of HMD-Form 1

Section 1: Disability and/or Medical Information

This section must be completed **in full** by the applicant for Social Housing Support.

Please tick (√) the box to show the category you are applying under.

Disability grounds ☐ Medical grounds ☐

Please state your disability and/or medical condition or those of any household member you are including in this form:

If you or a member of your household is a disabled person, please tick (√) which categories of disability apply to you or your household member.

Physical ☐ Mental Health ☐ Intellectual ☐ Sensory ☐

Section 2: Personal Details

This section must be filled out as outlined on page 2. Please make sure the details you input here are the same as on your Social Housing Application Form.

Please fill in the details of the main housing applicant below:

First name

Surname

PPS number

Date of Birth

Address

Telephone number

Email

If applicable, please provide the details of the household member you want to include in this form who is disabled and/or has a medical condition (if you need to include additional household members, please include an extra copy of this page for each additional household member):

First name

Surname

PPS number

Date of Birth

If the household member above is over the age of 18, they must sign below to consent to the sharing of their information with the local authority:

I permit the sharing of my medical information to the local authority to identify my housing needs.

Signature

Date

If applicable, please provide signature of Co-Decision Maker or Decision-Making Representative appointed to work with the household member identified above:

First name

Surname

Signature

Date

Declaration from main housing applicant/s:

I/we permit the Healthcare Professional in Appendix A and B to provide information on my/our disability and/or medical condition to the local authority.

Signature of applicant 1

Date

Signature of applicant 2

Date

If applicable, please provide signature of Co-Decision Maker or Decision-Making Representative appointed to work with you:

First name

Surname

Signature

Date

Office use only

Housing reference number:

Date Tenancy commenced (Transfer only):

When was Medical Priority last applied for?

Part 2 of HMD-Form 1

Healthcare Professional (A)

NOTE: Please type this form when completing, but if writing you must use block capitals to ensure legibility.

This section must be completed by a Healthcare Professional.

Details of Healthcare Professional completing this form:

First name

Surname

Name of Organisation

Occupation

Registration Number

Email

Telephone

Please identify the person to whom you are providing professional healthcare services:

First name

Surname

PPS number

Date of Birth

Please indicate the professional service you provide to the disabled person or person with a medical condition, and the duration of time they have been engaged with your service.

Duration

Current Accommodation

In your professional opinion, is the accommodation in which the person is residing impacting negatively upon the person's disability or medical condition?

Yes ☐ No ☐

If yes, please explain below, and indicate whether you have visited their current accommodation:

Accommodation Needs

Based upon the information outlined above, in your professional opinion, how would moving to other accommodation meet the accommodation needs of the disabled person or person with a medical condition? Considerations for this may include:

- **Location (e.g., Proximity to amenities and services)**
- **Type of housing (e.g., Wheelchair liveable, wheelchair accessible, level access accommodation, standard accommodation)**
- **Design of housing (e.g., Accessibility features or other specific features, including additional bedrooms)**

Please detail below:

Support Needs of the Applicant

Are supports currently needed to enable the disabled person or person with a medical condition to live independently?

Yes ☐ No ☐

If yes, please provide details of support care package below:

Will the disabled person or person with a medical condition need any additional or new supports? Please provide details of the services you envisage will provide those supports.

Yes ☐ No ☐

Please provide details below:

Healthcare Professional Declaration

I declare that the information and details I have provided on this form are correct and true.

I agree to the local authority contacting me, if necessary, to verify the details I have provided.

Signature

Date

Please provide stamp from your service below if available:

If you require extra space to complete the form, please include additional pages.

Part 3 of HMD-Form 1

Healthcare Professional (B)

NOTE: Please type this form when completing, but if writing you must use block capitals to ensure legibility.

This section must be completed by a Healthcare Professional.

Details of Healthcare Professional completing this form:

First name

Surname

Name of Organisation

Occupation

Registration Number

Email

Telephone

Please identify the person to whom you are providing professional healthcare services:

First name

Surname

PPS number

Date of Birth

Please indicate the professional service you provide to the disabled person or person with a medical condition, and the duration of time they have been engaged with your service.

Duration

Current Accommodation

In your professional opinion, is the accommodation in which the person is residing impacting negatively upon the person's disability or medical condition?

Yes ☐ No ☐

If yes, please explain below, and indicate whether you have visited their current accommodation:

Accommodation Needs

Based upon the information outlined above, in your professional opinion, how would moving to other accommodation meet the accommodation needs of the disabled person or person with a medical condition? Considerations for this may include:

- **Location (e.g., Proximity to amenities and services)**
- **Type of housing (e.g., Wheelchair liveable, wheelchair accessible, level access accommodation, standard accommodation)**
- **Design of housing (e.g., Accessibility features or other specific features, including additional bedrooms)**

Please detail below:

Support Needs of the Applicant

Are supports currently needed to enable the disabled person or person with a medical condition to live independently?

Yes ☐ No ☐

If yes, please provide details of support care package below:

Will the disabled person or person with a medical condition need any additional or new supports? Please provide details of the services you envisage will provide those supports.

Yes ☐ No ☐

Please provide details below:

Healthcare Professional Declaration

I declare that the information and details I have provided on this form are correct and true.

I agree to the local authority contacting me, if necessary, to verify the details I have provided.

Signature

Date

Please provide stamp from your service below if available:

If you require extra space to complete the form, please include additional pages.