

Moorview House

SUPPORTING PEOPLE - FRAIL ELDERLY SCHEME
Owned & Operated by Heathlands Housing Association Ltd
Heathlands Drive
Prestwich
Manchester M25 9SB
Tel: 0161 772 4828

TENANCY APPLICATION FORM

PRIVATE & CONFIDENTIAL

Priority prior to assessment: URGENT / HIGH / MEDIUM / STANDARD / NOMINATION

PLEASE USE BLOCK LETTERS

Name of Applicant Mr / Mrs / Miss	Scheme / Home Visit: Date of Assessment:
Address of Applicant: _____ _____ _____	

Tel No: Mobile No: E-Mail:	Other means of contact:
Has the applicant ever held a Moorview House Tenancy before? YES / NO If yes, at what address?	

What expectations does the applicant have about supported housing?

Communication	
Applicants preferred method of contact:	By letter / by phone / by E-Mail / any of these Other: (Please list)
Is English your first language?	Yes / No If not, what is your first language?
Do you need a translate for speech or writing?	Speech / Writing
Do you have an advocate or someone who you would like to be present at any future meetings?	Yes / No If yes, please provide details:

Moorview House houses many different people, some of who will be like you and some may be different for you. Every tenant has equal rights and responsibilities

Moorview House has an Equal Opportunities Statement. Have you received a copy of this and read it? **Yes / No**

In order to assess your housing and support needs we need to ask you the following questions:

	Level of ability	Comments
Do you do your own cooking?	All / some / none	
Do you do your own shopping?	All / some / none	
Do you do your own housework?	All / some / none	
Do you do your own laundry?	All / some / none	

Do you receive support from anyone else? Please tick

Family	Home Care	Community Nurse
Meals on wheels	Day Centre	Luncheon Club
Community Alarm	GP	

Do you need, and if so who provides, any help e.g. with getting dressed, getting washed, bathing, getting to bed. This could be from family, friends or Social Services:

What aids or equipment do you use?

Is there anything that would help you to manage these tasks better?

Mobility		Comments
Can you move around your home easily?	Yes / No	
Do you have difficulty with stairs?	Yes / No	
Do you use lifts?	Yes / No	
Can you go out by yourself?	Yes / No	
<i>Do you use a:</i>		
Walking stick	Yes / No	
Zimmer frame	Yes / No	
Electric/wheelchair	Yes / No	
Scooter	Yes / No	
Would anything help you be more mobile?		

History of Falls		
	Number	Frequency
Yes / No (<i>delete one</i>)		
If Yes:		
1. How Many / How often?		
2. What injuries have you sustained and When?		
3. Do you have Dizzy Spells?	Yes / No	
4. Do you Trip Up?	Yes / No	
5. Do your legs give way?	Yes / No	

<u>ADDITIONAL NOTES</u>

ASSESSMENT OF APPLICANT'S PRESENT CARE NEEDS

<p>1. PERSONAL CARE</p> <p>FOR WASHING AND DRESSING</p> <p><input type="checkbox"/> Fully Independent</p> <p><input type="checkbox"/> Supervision/Minimal Assistance</p> <p><input type="checkbox"/> Dependant on One Carer</p> <p><input type="checkbox"/> Needs Full Assistance</p> <p>FOR BATHING OR SHOWERING</p> <p><input type="checkbox"/> Fully Independent</p> <p><input type="checkbox"/> Supervision/Minimal Assistance</p> <p><input type="checkbox"/> Dependant on One Carer</p> <p><input type="checkbox"/> Needs Full Assistance</p>	<p>ADDITIONAL NOTES</p>
<p>2. FOR NUTRITIONAL FEEDING</p> <p><input type="checkbox"/> Fully Independent</p> <p><input type="checkbox"/> Supervision/Minimal Assistance</p> <p><input type="checkbox"/> Dependant on One Carer</p> <p><input type="checkbox"/> Needs Full Assistance</p> <p><input type="checkbox"/> Special Needs (See Notes) PEG</p>	<p>ADDITIONAL NOTES</p>
<p>3. MEMORY</p> <p><input type="checkbox"/> No Concerns</p> <p><input type="checkbox"/> Occasionally forgetful</p> <p><input type="checkbox"/> Poor / Short term memory</p> <p><input type="checkbox"/> Disorientated in time / place</p>	<p>ADDITIONAL NOTES</p>

<p>4. FOR CONTINENCE MANAGEMENT</p> <p><input type="checkbox"/> Fully Continent / Incontinent</p> <p><input type="checkbox"/> Occasionally accidents</p> <p><input type="checkbox"/> Continent if toileted / prompted</p> <p><input type="checkbox"/> Day / Night Time</p> <p><input type="checkbox"/> Catheterised / Special Needs</p> <p>BOWELS</p> <p><input type="checkbox"/> Fully Continent / Incontinent</p> <p><input type="checkbox"/> Occasionally accidents</p> <p><input type="checkbox"/> Continent if toileted / prompted</p> <p><input type="checkbox"/> Day / Night Time</p> <p><input type="checkbox"/> Stoma / Special Needs</p>	<p>ADDITIONAL NOTES</p>
<p>5. RISK FACTORS</p> <p><input type="checkbox"/> Moving / Handling</p> <p><input type="checkbox"/> Mental Health</p> <p><input type="checkbox"/> Non compliance</p> <p>General Body Frame</p> <p><input type="checkbox"/> Small</p> <p><input type="checkbox"/> Medium</p> <p><input type="checkbox"/> Large</p> <p><input type="checkbox"/> Infections e.g. MRSA</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Smoker / Non Smoker</p> <p><input type="checkbox"/> Prosthesis (See Notes)</p> <p><input type="checkbox"/> Violence</p>	<p>ADDITIONAL NOTES</p>

ASSESSMENT OF APPLICANT'S SUPPLEMENTARY CARE

<p>1. HEARING AND VISION</p> <p>FOR HEARING</p> <p><input type="checkbox"/> No Difficulties</p> <p><input type="checkbox"/> Slightly Hard of Hearing</p> <p><input type="checkbox"/> Severe Deficiency</p> <p><input type="checkbox"/> Wears Hearing Aid</p> <p><input type="checkbox"/> Special Needs (Aids, Lip Reading)</p> <p>FOR VISION</p> <p><input type="checkbox"/> No Difficulties</p> <p><input type="checkbox"/> Slightly Deficient</p> <p><input type="checkbox"/> Severe Deficiency</p> <p><input type="checkbox"/> Wears Glasses</p> <p><input type="checkbox"/> Special Needs (Registered Blind / Partially Sighted)</p>	<p>ADDITIONAL NOTES</p>
<p>2. COMMUNICATION</p> <p><input type="checkbox"/> No Difficulties / Full Expression</p> <p><input type="checkbox"/> Indicates Needs</p> <p><input type="checkbox"/> Language Barrier</p> <p><input type="checkbox"/> Understands Basic Instructions</p> <p><input type="checkbox"/> Special Needs (See Notes)</p>	<p>ADDITIONAL NOTES</p>
<p>3. SLEEP PATTERNS</p> <p><input type="checkbox"/> No Difficulties</p> <p><input type="checkbox"/> Disturbed Sleep</p> <p><input type="checkbox"/> Needs Assistance During the Night</p> <p><input type="checkbox"/> Uses Medication / Self Medicating</p> <p><input type="checkbox"/> Special Needs (See Notes)</p>	<p>ADDITIONAL NOTES</p>

<p>4. MEMORY FUNCTION</p> <p><input type="checkbox"/> Fully Aware</p> <p><input type="checkbox"/> Memory Incomplete</p> <p><input type="checkbox"/> Short Term Memory Loss</p> <p><input type="checkbox"/> Just Forgetful</p> <p><input type="checkbox"/> Long & Short Term Loss</p> <p><input type="checkbox"/> Extremely Confused and Disoriented</p>	<p>ADDITIONAL NOTES</p>
<p>5. EMOTIONAL STATE</p> <p><input type="checkbox"/> In Good Spirits</p> <p><input type="checkbox"/> Appears Lonely</p> <p><input type="checkbox"/> Appears Nervous</p> <p><input type="checkbox"/> Appears Anxious</p> <p><input type="checkbox"/> Withdrawn / Depressed</p>	<p>ADDITIONAL NOTES</p>
<p>6. CARERS STRESS LEVELS</p> <p><input type="checkbox"/> No Existing Problems</p> <p><input type="checkbox"/> Has Some Difficulties but Coping</p> <p><input type="checkbox"/> High Stress Levels</p> <p><input type="checkbox"/> Feels Unable to Continue</p> <p><input type="checkbox"/> Refer to Counsellor, SW, GP</p>	<p>ADDITIONAL NOTES</p>
<p>7. GROUP LIVING ENVIRONMENT</p> <p><input type="checkbox"/> Would be No Problem</p> <p><input type="checkbox"/> Does Not Mix Anyway</p> <p><input type="checkbox"/> Could be Demanding / Disruptive</p> <p><input type="checkbox"/> Refer to O.T./A.C.</p> <p><input type="checkbox"/> Refer to Counsellor</p> <p><input type="checkbox"/> Wishes to attend Shule</p> <p><input type="checkbox"/> Not a regular Shule Attender</p> <p><input type="checkbox"/> Needs Special Care Environment</p>	<p>ADDITIONAL NOTES</p>

Please describe any skin integrity problems, to include treatments and dressings.

Please summarise any other relevant nursing or special care needs not mentioned elsewhere, e.g. need for anti-pressure mattress, special needs pain control etc.

MENTAL HEALTH AND EMOTIONAL STATUS

1. Please summarise any levels of a dementia process, and support needed.

2. Please summarise any known diagnosis of a mental illness to include Neurosis...Psychosis...Depression...Mood Swing Disorder...Delusion...Hallucination...Cognition.

3. Where known, give details of Consultant Psychiatric or C.P.N. input to include inpatient stays.

4. Please summarise any known care issues surrounding Orientation...Memory Loss...Agitation...Confusion...Aggression...Anxiety...Behavioural Problems...Non-compliance...

Previous Health

Please give details of any previous medical and surgical history relevant to this application.

Current Health

Do you suffer from any form of ill health e.g. heart, arthritis, depression, etc?

Please give details:

List any care / support that you receive in relation to illness / poor health:

Do you need any assistance taking your medication?

What is your preferred method when taking your medication? i.e. Bottles, Blister packs etc

Social and Leisure Interests

Do you belong to any clubs / organisations or have hobbies that you want to continue, or take up?
(Please list):

Do you have any pets? **Yes / No**

List Pets (if any):

Cultural and faith needs

Do you have any cultural or faith needs that Moorview House need to know, so that we can provide you with an appropriate service?

Setting up Home

Would you require any help in setting up a new home? e.g. benefits advice, adaptations, furnishing:

Claiming Welfare Benefits

Moorview House can help with confidential benefits advice and with making claims for welfare benefits. Would you find this helpful?

Is there anything else that you would like to tell us about your support / care needs?**Applicants contacts**

	First Contact	Second Contact
Name of next kin		
Address		
Telephone		
Relationship to you		

APPLICANT'S COMMUNITY CARE TEAM (WHERE APPROPRIATE)**1. SOCIAL SERVICES**

Social Workers Name: _____

Social Workers Office/Team Address: _____

Contact No's – Office No: _____ Fax No: _____

2. GENERAL PRACTITIONER

GP's Name: _____

GP's Surgery Address: _____

Contact No's – Surgery No: _____ Fax No: _____

3. **DISTRICT NURSING SERVICE**

District Nurses Name: _____

Practice Address: _____

Contact No's – Practice No: _____ Fax No: _____

4. **C.P.N. SERVICE**

C.P.N.'S Name: _____

Practice Address: _____

Contact No's – Practice No: _____ Fax No: _____

5. **OTHER, PLEASE SPECIFY e.g. Named Nurse, Key Worker**

Name: _____

Address: _____

Contact No's – Practice No: _____ Fax No: _____

The needs assessment contains what I consider my main support / care needs at this present time. I am signing to say that I agree with this content. I understand that this is a confidential document. This means that the only people who have access to this information ware myself and staff on a “need to know” basis.

Would you like a copy of this needs assessment form? **Yes / No**

Applicant

Signed: _____ **Date:** _____

Interviewing Officer

Signed: _____ **Date:** _____

Further action – to be completed by person carrying out initial needs assessment.	
Is the application in the correct band? If no, please state which setting is appropriate and why:	Yes / No
Does the application meet the necessary criteria for an “independent living” setting?	Yes / No
Home visit or further information / assessment required? Comments:	Yes / No
Other preferences to be recorded:	Single Room / Double Room
Signed: _____ Dated: _____	

For office use	
Confirmation of setting	
Home visit arranged	Yes / No / Not Applicable
Further info required (recorded on file)	Yes / No
Copy of Needs Assessment form required by applicant and sent	Date
Copy of Needs Assessment form sent to scheme manager(s)	Date
Signed: _____ Dated: _____	
NB. Details of all allocations decisions to be recorded on applicants file	

Outcome of any Further Assessment
Signed: _____ Dated: _____

I declare that to the best of my knowledge the information contained herein is true.

Signature of Interviewing Officer: _____

Date: _____

Signature of Applicant: _____

Date: _____