Health & Wellbeing:

Supporting Evidence Form

Version: SE July 2025

This form is used to help us assess how your health or wellbeing is affected by your current accommodation.

A professional worker **must** complete this form. For example:

- Occupational Therapist
- Member of the Community Mental Health Team
- Social Worker
- Consultant
- Health and Social Care Worker
- Substance Misuse Worker
- Support Agency Worker

Important: Please do not ask your GP to complete this form unless they have confirmed that they are happy to do so without charge

Consent to provide information: You must complete and sign this section before requesting that this form is completed by a professional. Please note that local authorities may accept existing OT assessments, care plans, GP or consultant letters, PIP confirmation letters etc. rather than requiring that professionals complete a Supporting Evidence form, provided that the information is up to date and relates to the situation in your current home. Please contact your local authority if you have any queries relating to the provision of supporting evidence.

If you are asked to pay a fee for the completion of this form or if you are unable to get the form completed by one of the professionals working with you please contact your local authority to discuss alternative options to provide evidence of your health and wellbeing need.

Consent to provide information:

I give permission to the professional named on this form to provide the information requested.

I understand that this information will be used to assess how my health and wellbeing is affected by my current accommodation.

I wish / do not wish (delete as applicable) to see the completed form before it is sent to the local authority managing my Devon Home Choice application.

I understand that the Devon Home Choice partners will not make any payment for this form to be completed.

I understand that I do not need to contact my GP directly about my Devon Home Choice application. Any contact with your GP will be made by the local authority managing your application.

This form is to be signed by the person whose health or wellbeing is being affected by your current accommodation, or lack of accommodation. Except please note that if the person named on this form is under 16 we will need the signature of a parent/guardian. Please make the relationship clear below.

Details of the person whose health or wellbeing is being affected by their current accommodation.

Title First Name(s) Surname

Male Female Other Date of Birth

Devon Home Choice Application Number

Address (including postcode)

Phone number

Signed

Name of person signing this consent

Relationship to person whose health or wellbeing is affected by their current accommodation (if applicable) Date

If you are completing this form on behalf of someone else, do you have a Power of Attorney to act on their behalf? Yes No

A. Name and contact details of professional worker

Title First Name(s) Surname

Position held Organisation

Address & contact details

Address 1

Address 2

Postcode

Phone No.

Email

B. Condition(s) being affected by your client's current accommodation

Please name the condition(s) your client suffers from and how their health and wellbeing is affected by their current accommodation. Please only give details of conditions that are affected by your client's current accommodation (E.g. that affects their ability to remain in, access or move around in their home etc).

Please do not give details of conditions that are not affected by your client's accommodation or could not be resolved by moving to a new home.

Condition 1

Please name this condition:

Please tick the boxes below that best describe your client's condition:

- ☐ Diagnosed chronic
- ☐ Diagnosed degenerative
- ☐ Managed with medication
- ☐ No need for medication

How does your client's current accommodation impact on this condition? (E.g. are there stairs your client cannot manage, have they had any falls, are there essential facilities in the home that they are unable to access, is their mental health adversely affected etc.?)

How does your client currently manage this condition in their current accommodation?

Does your client take medication for this condition? Yes No

If Yes, please provide details (e.g. the name and dosage of any medication)

Condition 2

Please name this condition:

Please tick the boxes below that best describe your client's condition:

- Diagnosed chronic
- Diagnosed degenerative
- Managed with medication
- No need for medication

How does your client's current accommodation impact on this condition? (E.g. are there stairs your client cannot manage, have they had any falls, are there essential facilities in the home that they are unable to access, is their mental health adversely affected etc.?)

How does your client currently manage this condition in their current accommodation?

Does your client take medication for this condition? Yes No

If Yes, please provide details (e.g. the name and dosage of any medication)

Condition 3

Please name this condition:

Please tick the boxes below that best describe your client's condition:

- Diagnosed chronic
- Diagnosed degenerative
- Managed with medication
- No need for medication

How does your client's current accommodation impact on this condition? (E.g. are there stairs your client cannot manage, have they had any falls, are there essential facilities in the home that they are unable to access, is their mental health adversely affected etc.?)

How does your client currently manage this condition in their current accommodation?

Does your client take medication for this condition? Yes No

If Yes, please provide details (e.g. the name and dosage of any medication)

Condition 4

Please name this condition:

Please tick the boxes below that best describe your client's condition:

- Diagnosed chronic
- Diagnosed degenerative
- Managed with medication
- No need for medication

How does your client's current accommodation impact on this condition? (E.g. are there stairs your client cannot manage, have they had any falls, are there essential facilities in the home that they are unable to access, is their mental health adversely affected etc.?)

How does your client currently manage this condition in their current accommodation?

Does your client take medication for this condition? Yes No

If Yes, please provide details (e.g. the name and dosage of any medication)

2. What physical aspects of the property are impacting on the health and/ or wellbeing of your client? For example hilly area, steps, the layout of the home etc.

3. Is your client working with any other health related agencies to help manage their condition(s)? ☐ Yes ☐ No

If Yes, please provide the following details:

Name:

Role:

Organisation:

Phone number: Email:

C. Care and support

4. Does your client have a carer? ☐ Yes ☐ No

If 'Yes' is the care?
(Please tick all that apply)

☐ Formal (e.g. a paid carer) ☐ Informal (e.g. provided by a family member or friend)

☐ Live-in ☐ 3 times a week or more ☐ Twice a week or less

What help does your client's carer provide?

☐ Personal care ☐ Shopping for food ☐ Preparing food
☐ Giving medication ☐ Paying bills ☐ Attending appointments
☐ Other (please detail)

Please provide your client's carer's:

Name:

Phone number: Email:

5. Does the impact of your client's accommodation on their condition(s) affect their ability to undertake any of the following?

(Please tick all that apply)

☐ Personal Care ☐ Shopping for food ☐ Preparing food
☐ Taking medication ☐ Paying bills ☐ Attending appointments
☐ Other (please detail)

D. Type of accommodation needed

6. Which features are required by your client?

Please choose 1 of the options below

- [ ] A fully wheelchair accessible home
- [ ] A step free home
- [ ] A home with a maximum of 3 steps into/out of it
- [ ] None of the above (i.e. your client has no mobility needs)

Please tick all options that apply below

- [ ] Level surrounding area
- [ ] Disabled parking
- [ ] Stairlift
- [ ] Level access shower
- [ ] Scooter (assessed need)
- [ ] Being close to family/ friends for support*
- [ ] Other (please detail)

*The applicant would have to provide evidence that this is essential care by the family

7. If the property needs to be wheelchair accessible please tick the type of wheelchair your client uses, and provide the measurements:

Please tick all that apply

- [ ] Manual self propelled
- [ ] Manual attendant controlled
- [ ] Powered indoor
- [ ] Powered outdoor
- [ ] Powered indoor / outdoor
- [ ] Other

Dimensions of wheelchair

Minimum door width

Minimum turning circle

8. Please detail whether adaptions to your client's current accommodation would improve their health and/or well being. If so:

Have adaptations been applied for? Yes No

Is funding in place for the adaptations? Yes No

If Yes, please provide details

E. Risk

9. Does your client pose a risk to others, or has ever been assessed as posing a risk to others? Yes No

If 'Yes', please supply the risk assessment.

Data protection

All personal information will be held and processed in accordance with the requirements of the General Data Protection Regulation (Regulation (EU) 2016/679) and the Data Protection Act 2018.

Please see the Privacy Notice on the Devon Home Choice website (www.devonhomechoice.com) for details of what personal data is collected and how it is used.

Signature of professional worker

Date / /

DD MM YYYY

Please return the completed form to: